CMS Manual System

Pub. 100-24 State Payment of Medicare Premiums

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 7 **Date: 01/16/2025**

SUBJECT: Updates to several sections in Chapter 1 of the State Payment of Medicare Premiums Manual.

I. SUMMARY OF CHANGES: This update to the State Payment of Medicare Premiums manual (formerly called "State Buy-in Manual") revises policy instructions in chapter one of the manual to provide further instructions to states on implementing provisions of the Sept. 21, 2023, Medicare Savings Program (MSP) Eligibility and Enrollment final rule and to include technical edits related to MSP enrollment and state buy-in.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: January 16, 2025
IMPLEMENTATION DATE: January 16, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	TOC
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III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

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***Unless otherwise specified, the effective date is the date of service.**

Program Overview and Policy
Chapter 1

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(Rev. 7; Issued: 01-16-2025)

1.0 Introduction

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

Since the inception of the Medicare program in 1966, section 1843 of the Social Security Act ("the Act") has afforded states the option to enter into an agreement with the federal government under which the state commits to enrolling certain individuals dually eligible for Medicare and Medicaid (dually eligible individuals) in Medicare Part B with the state paying the Part B premiums on their behalf. Under section 1818(g) of the Act, starting January 1, 1990, states could amend these agreements to pay the Part A premiums for certain dually eligible individuals who must pay a premium to enroll in Medicare Part A. Section 1903(a)(1) and (b) of the Act authorizes Federal Financial Participation (FFP) for the payment of Part A and/or Part B premiums and cost-sharing for certain dually eligible individuals.

The Centers for Medicare & Medicaid Services (CMS), through authority delegated by the Department of Health and Human Services (HHS), administers this process of state payment of Medicare premiums, historically referred to as "state buy-in."

This chapter sets forth consolidated policy guidance regarding the state buy-in program for the 50 states and the District of Columbia. Forthcoming program instructions will apply to the U.S. territories identified in 42 CFR 407.42 and 407.43.

NOTE: This manual contains links to the Social Security Administration (SSA) Program Operations Manual System (POMS) as of January 1, 2024.[1]

1.1 Definitions

(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

Buy-in Agreement means an agreement authorized or modified by sections 1843 or 1818(g) of the Act, under which a state secures Part B or premium Part A coverage for "eligible individuals" (see definition below) who are members of the buy-in group specified in the agreement, by enrolling them and paying the premiums on their behalf. See 42 CFR 407.40(b). Starting January 1, 2023, a state's Medicaid state plan ("state plan") pages, including any modifications under a state's Medicaid state plan amendments (SPAs), related to buy-in policy constitute the "buy-in agreement" between the state and CMS for purposes of sections 1843 and

[1] The Social Security Administration's Program Operating Manual System ("SSA POMS") is the main reference for SSA employees to conduct daily business, including actions related to the state payment of Medicare premiums. As a courtesy to states, CMS provides links to the SSA POMS as of the time the manual was published. Changes may occur after release. To access the SSA POMS, go to https://secure.ssa.gov/apps10/poms.nsf/Home?readform.

1818(g) of the Act and supersedes the free-standing buy-in agreements that all states and U.S. territories originally signed with CMS. See 42 CFR 407.40(b).[2]

Buy-in Group (also known as a "buy-in coverage group") means a coverage group described in section 1843 of the Act that is identified by the state and is composed of multiple Medicaid eligibility groups specified in the buy-in agreement. 42 CFR 407.40(b).

Eligible Individual (for Part B) means an individual who is entitled to Medicare Part A or who is age 65 or over, is a resident of the United States and is either a U.S. citizen, or an alien lawfully admitted for permanent residence who has resided in the U.S. continuously during the five years immediately preceding the month the individual applies for enrollment under Part B, and has not been convicted of crimes specified in 42 CFR 407.10(b). See section 1836 of the Act; 42 CFR 407.10.

Entitled to Medicare Part A refers to individuals who receive Part A, either without payment of a premium (premium-free Part A) under 42 CFR 406.5(a) or by paying a premium (premium Part A) under 42 CFR 406.5(b).

General Enrollment Period (GEP) for Part B means the annual period (January 1 through March 31) for an individual to apply for Part B if the individual did not apply during their Initial Enrollment Period (IEP). See 42 CFR 407.15.

General Enrollment Period (GEP) for Premium Part A means the annual period (January 1 through March 31) for an individual to apply for Premium Part A if the individual did not apply during their IEP. See 42 CFR 406.21(c).

Group Payer Arrangement is a method which certain third parties (e.g., states) use to pay the Parts A and/or Part B premiums for a class of beneficiaries. See 42 CFR 406.32(g) and 408.80; SSA POMS HI 01001.230 at https://secure.ssa.gov/poms.nsf/lnx/0601001230.[3] States that do not include Part A in their buy-in agreements must pay the Part A premiums for Qualified Medicare Beneficiaries (QMBs) using the group payer arrangement.

Initial Enrollment Period (IEP) means the seven-month period that begins three months before the month an individual first becomes eligible to enroll in premium Part A or Part B and ends three months after that first month of eligibility. See 42 CFR 406.21(b) and 407.14.

Member of a Buy-in Coverage Group means an individual who is a member of the buy-in coverage group that the state has elected to include in its buy-in agreement. States may only

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[2] To execute agreements under section 1843 of the Act, the Secretary and states initially executed free-standing written agreements that defined the then-scope of a state's buy-in agreement and bound the state to follow federal regulations and guidance under section 1843 of the Act.

[3] States may not use the group payer arrangement to pay the Part B premiums on behalf of individuals whose premiums are deducted from monthly Social Security benefits or whose premiums are paid under a state buy-in agreement. See 42 CFR 408.82(b)(2).

cover under state buy-in an eligible individual who is a member of the buy-in group. See 42 CFR 406.20, 407.40, 407.42, and 407.43.

Premium Increase for Late Enrollment (also known as "Late Enrollment Penalty") means the additional amount that may be charged to an individual who enrolls in premium Part A or Part B after expiration of the individual's IEP or who reenrolls after previous coverage. For Part B, the premium is increased ten percent for each cumulative period of 12 full months during which an individual could have been, but was not enrolled in Part B. See 42 CFR 408.22. For premium Part A, effective for premiums due for July 1986 and after, the premium increase is limited to ten percent and is payable for twice the number of full 12-month periods determined under the regulations. See 42 CFR 406.32(d).

Premium Part A means the hospital insurance benefits provided under Medicare Part A for certain individuals who do not qualify for Part A without monthly premiums under 42 CFR 406.5(a) and can only enroll in Part A by paying a premium. See 42 CFR 406.5(b) and 406.20.

Special Enrollment Period (SEP) means a period outside of the IEP and GEP during which an individual can enroll in premium Part A or Part B. There are several SEPs, including an SEP for an individual who is or was covered by an employer group health plan under 42 CFR 406.24 and 407.20, an individual who volunteered outside of the U.S. under 42 CFR 406.25 and 407.21, and certain individuals who were enrolled in TRICARE coverage under section 1837(l) of the Act. Additionally, starting January 1, 2023, there are five SEPs for exceptional circumstances, including: for individuals impacted by an emergency or disaster; for individuals affected by a health plan or employer misrepresentation; for formerly incarcerated individuals; for individuals who lose Medicaid coverage;[4] or for other exceptional circumstances. See 42 CFR 406.27 and 407.23; SSA POMS HI 00805.382 at https://secure.ssa.gov/poms.nsf/lnx/0600805382.

[4] The loss of Medicaid SEP starts the month the state notifies the individual they have lost all Medicaid coverage and ends six months after the Medicaid termination. For more information about this SEP, see SSA POMS HI 00805.385 at https://secure.ssa.gov/poms.nsf/lnx/0600805385.

1.2 Background

(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

Medicare provides health insurance coverage to individuals age 65 and older and certain persons under age 65 with disabilities or End-Stage Renal Disease (ESRD). Medicare Part A provides coverage generally of inpatient care, and most beneficiaries are entitled to these benefits without paying an additional premium based on eligibility for Social Security or Railroad Retirement Board (RRB) benefits. Some individuals are eligible to obtain entitlement to Part A benefits by enrolling in premium Part A. Medicare Part B, which is optional and requires payment of a premium, covers most other types of health coverage, including limited prescription drug coverage. Medicare Part D, also optional, requires a premium, and covers outpatient prescription drugs. Medicare Parts A, B, and D all require payment of cost-sharing (e.g., deductibles, coinsurance, and copayments).

Under the state buy-in program, states, the District of Columbia, and U.S. territories can enter into buy-in agreements that make it easier to enroll certain Medicaid beneficiaries into Medicare Part B and pay the premiums on their behalf ("Part B buy-in"). See section 1843 of the Act; 42 CFR 407.40, et seq. All states, the District of Columbia, and three U.S. territories (the Commonwealth of Northern Mariana Islands, Guam, and the U.S. Virgin Islands), have elected to enter into a Part B buy-in agreement with CMS.

Since January 1, 1990, states have had the option to expand their buy-in agreements to enroll QMBs in premium Part A and pay the premiums on their behalf ("Part A buy-in"). See sections 1.7 and 1.11 for more information about paying Part A premiums for QMBs.

For an individual who is determined eligible for but not yet enrolled in Medicare, state buy-in serves to enroll the individual in Medicare Part A and/or B and directs the federal government to bill the state for their premiums. For an individual who is already enrolled in Medicare, state buy-in means the federal government will start billing the state for the individual's Medicare premiums and stop billing the individual for these costs through deductions from their monthly Social Security benefits (Old Age, Survivors, and Disability Insurance (OASDI) program)[5] or through bills CMS directly mails certain beneficiaries.[6]

The impact of state buy-in is significant for many beneficiaries. Low-income individuals who receive assistance with Medicare premiums save critical funds to use for other life necessities,

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[5] OASDI benefits include Old Age Insurance Benefit Payments (also known as Social Security retirement benefits) and Social Security Disability Insurance (SSDI).

[6] CMS sends the beneficiary a Medicare Premium Bill (CMS-500) (see https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS500.pdf) for Medicare Parts A and/or B if the beneficiary's premium liability exceeds the amount of the beneficiary's Social Security benefit or Office of Personnel Management (OPM) or Railroad Retirement Board (RRB) annuity or the beneficiary is not receiving any of these benefits. Most beneficiaries pay the standard Part B premium amount ($174.90 in 2024). States also pay the standard Part B premium amount on behalf of individuals enrolled in buy-in. See SSA POMS HI 01001.004 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0601001004.

including food and housing. Upon state buy-in, individuals who were paying the Medicare premiums through deductions from their Social Security or RRB benefits see a notable increase in their monthly payments, and individuals eligible but not enrolled in Medicare are able to enroll in the program and access Medicare services. Buy-in agreements also enable individuals to enroll in Medicare at any time of the year, without regard for Medicare enrollment periods and late enrollment penalties.

Buy-in agreements simplify the process for states to assist their low-income residents with Medicare expenses. Maximizing the number of Medicaid beneficiaries who are also enrolled in Medicare is advantageous to the individuals and can also result in cost savings for states. Medicare pays primary to Medicaid for Medicare Part A (inpatient hospital and skilled nursing facility services) and Medicare Part B (outpatient medical care). In addition, Medicaid beneficiaries who are enrolled in both Medicare Parts A and B may join Medicare-Medicaid integrated care plans, which can improve coordination of care for dually eligible beneficiaries. The state's regular Federal Medical Assistance Percentage (FMAP) rate applies to state expenditures for Medicare Parts A and B premiums and cost-sharing for certain Medicaid eligibility categories (see section 1.9).

1.3 Medicare Eligibility and Enrollment

(Rev. 6; **Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)**

CMS regulations require states to enroll members of a buy-in group in buy-in if they meet the requirements for Medicare Parts A and/or B (an "eligible individual" as defined in section 1.1). See 42 CFR 406.26(a) and 407.40(c).

This section summarizes Medicare eligibility requirements and enrollment processes to help states understand which Medicaid beneficiaries may qualify for Medicare and become dually eligible.

1.3.1 Premium-free Part A

(Rev. 6; **Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)**

Certain individuals qualify for premium-free Part A if they have enough Social Security work credits to qualify for monthly OASDI benefits.[7] Most Medicare beneficiaries get premium-free Part A.

An individual age 65 or over meets the requirements for premium-free Part A if the individual:

- Already gets Old Age Insurance Benefit Payments (Social Security retirement benefits)

[7] An individual accrues Social Security work credits when the individual pays Medicare payroll taxes while working. See 20 CFR part 404, subpart B.

or an Age and Service Annuity from the RRB (RRB retirement benefits);

- Is eligible to get Social Security or RRB retirement benefits but has not filed for them yet; or

- Is a government employee who paid the Medicare payroll tax while working for the required amount of time.

An individual under age 65 meets the requirements for premium-free Part A if the individual has received Social Security Disability Insurance (SSDI) or a disability annuity from RRB (RRB disability benefits) for 24 months; or

An individual of any age who has ESRD meets the requirements for premium-free Part A if the individual:

- Has the requisite work credits; or

- Is a spouse or dependent child[8] of an individual who has the requisite work credits.

All individuals who qualify for Medicare on the basis of ESRD and individuals who qualify for Medicare based on the receipt of SSDI receive premium-free Part A.

NOTE: An individual who has ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig's disease) qualifies for premium-free Part A the month the individual's SSDI benefits begin.

For more information about eligibility for premium-free Part A, see section 10 of the Medicare General Information, Eligibility and Entitlement Manual at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/ge101c02.pdf.

1.3.2 Premium Part A

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

Individuals who lack the requisite Social Security work credits to qualify for OASDI can obtain premium Part A. See 42 CFR 406.5(b). CMS directly bills such individuals for Part A premiums. See 42 CFR 406.32(e).

Individuals age 65 or older qualify for premium Part A under section 1818 of the Act and 42 CFR 406.20(b) if they are U.S. residents:

- Receiving benefits under Part B or are in the process of enrolling in it;

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[8] For information about qualifying for ESRD Medicare as a dependent child, see SSA POMS HI 00801.201 at https://secure.ssa.gov/poms.nsf/lnx/0600801201.

- Not otherwise entitled to Part A; and
- Either:
    - U.S. citizens; or
    - Lawful permanent residents who have resided in the U.S. continuously during the five years immediately preceding the month they applied for enrollment in Medicare.[9]

In addition, individuals with disabilities under age 65 who return to work may qualify for premium Part A (premium Part A for the Working Disabled) if they meet all of the following criteria:

- Were entitled to premium-free Part A on the basis of entitlement to SSDI;
- Have lost premium-free Part A (premium-free Part A continues 8 and 1/2 years after a return to work, including a 9-month trial work period, as described in SSA POMS DI 55001.001B.2.b at https://secure.ssa.gov/poms.nsf/lnx/0455001001);

  Are not otherwise entitled to Part A; and
- Continue to have a qualifying disability. (See section 1818A of the Act; 42 CFR 406.20(c).)

Individuals who enroll in premium Part A for the Working Disabled can also enroll in Part B, but they are ineligible to enroll in Part B alone. See SSA POMS HI 00801.170 at https://secure.ssa.gov/poms.nsf/lnx/0600801170.

NOTE: Individuals with disabilities who return to work may, if determined eligible and the state provides the coverage at issue, qualify for full-benefit Medicaid, including mandatory Medicaid coverage for working individuals under 1619(b) of the Act and optional Medicaid buy-in groups for working individuals described in sections 1902(a)(10)(A)(ii)(XIII) (XV), and (XVI) of the Act. Working individuals with disabilities who are otherwise ineligible for Medicaid benefits may qualify for the Qualified Disabled and Working Individual (QDWI) Medicare Savings Program group through which Medicaid covers their Part A premiums.[10]

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[9] The five years of continuous residence may begin prior to the date that the lawful admission for permanent resident is granted. See SSA POMS HI 00805.005 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600805005 and SSA POMS GN 00303.800 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0200303800.

[10] The QMB group is not available to individuals who enroll in premium Part A for working disabled individuals. See section 1905(p)(1)(A) of the Act; 42 CFR 400.200 and 435.123. For more information about the QMB group, see section 1.6.2.4.

For more information about the QDWI eligibility group, see section 1.6.2.

Individuals may qualify to pay a reduced monthly Part A premium under certain circumstances.[11] See 42 CFR 406.32(c).

For more information about eligibility for Premium Part A, section 10 of the Medicare General Information, Eligibility and Entitlement Manual at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/ge101c02.pdf.

1.3.3 Medicare Part B

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

Unlike Part A, there is always a premium for Part B.[12]An individual who receives OASDI, RRB, or Office of Personnel Management (OPM) government retirement benefits must pay the Part B premium through a deduction from their monthly benefits. The exception to mandatory deduction is if a state pays the individual's premiums under a buy-in agreement. See section 1840(h) of the Act.

CMS directly bills individuals for their Medicare premiums if they do not receive OASDI, RRB or OPM benefits. SSA manually bills individuals whose OASDI is less than the premium amount owed,[13] for Part B premiums. See section 1840(e) of the Act; 42 CFR 408.60.

Individuals who are entitled to Part A are also eligible to enroll in Medicare Part B. See section 1836 of the Act. Individuals who lack the requisite OASDI work history for premium-free Part A can enroll in Part B alone (or can enroll in both Part B and premium Part A) if they are age 65 or older and meet the citizenship and residency requirements for Part B**.** See 42 CFR 407.10(a)(2). In other words, they must be:

- Age 65 or older;

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[11] Individuals may qualify for a reduced premium if they have obtained 30 work credits; are married for at least one year to a worker with at least 30 work credits; were married for at least one year to a worker who attained 30 work credits prior to their death; are divorced from a worker after 10 years of marriage and the worker attained 30 work credits at the time the divorce was final; or are divorced from a worker after 10 years of marriage and the worker died and had 30 work credits at the time the divorce was final. See 42 CFR 406.32(c).

[12] Note that Medicare Advantage plans can reduce the standard Medicare Part B premium as an additional benefit for plan enrollees. The reduction must be less than the standard Part B premium amount and cannot be paid to the beneficiary or used to reduce a late enrollment penalty. If an individual receives a Part B premium deduction from a Medicare Advantage plan and is enrolled in Part B buy-in, CMS will notify the state of the amount of the premium reduction through the regular exchange of buy-in data.

[13] If the amount of the Part B premium exceeds the individual's OASDI payment, SSA applies the full of amount of the benefit payment to the premium, and SSA directly bills the beneficiary for the remaining balance owed. See SSA POMS HI 01001.041 at https://secure.ssa.gov/poms.nsf/lnx/0601001041.

- U.S. residents; and
- Either:
  - U.S. citizens; or
  - Lawful permanent residents who have resided in the U.S. continuously during the five years immediately preceding the month of application for enrollment in Medicare.[14]

1.3.4 The Part B Immunosuppressive Drug Benefit

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

Starting January 1, 2023, certain individuals who lose Medicare coverage based on ESRD 36 months after a successful kidney transplant are eligible for a limited Part B Immunosuppressive Drug (Part B-ID) benefit that covers immunosuppressive drug therapy under Part B, as required by section 402 of the Consolidated Appropriations Act, 2021 (CAA, 2021).

The Part B-ID benefit solely covers immunosuppressive drugs and no other Medicare items, services, or prescription drugs.

Individuals are charged a monthly premium for Part B-ID ($110.40 in 2025), and most are directly billed by CMS. Current premium amounts can be found in the "What's the Immunosuppressive Drug Benefit" section of the ESRD Medicare webpage at: https://www.medicare.gov/basics/end-stage-renal-disease#:~:text=Beginning%20January%201%2C%202023%2C%20Medicare,substitute%20for%20full%20health%20coverage.

States pay the Part B-ID premium as well as cost-sharing (Part B-ID benefit deductible and coinsurance) for individuals determined eligible for the QMB eligibility group. See section 1.6.2.4. States pay the Part B-ID premium for individuals determined eligible for the Specified Low Income Medicare Beneficiary (SLMB) or QI (Qualifying Individuals) eligibility groups See sections 1.6.2.7 and 1.6.2.8.

On or after January 1, 2023, individuals are eligible for Part B-ID if they:

- Lose Medicare entitlement on the basis of ESRD 36 months after a successful kidney transplant;
- Are not otherwise enrolled in Medicare or certain other forms of health coverage; and
- Complete an attestation through SSA certifying that they do not have or expect to obtain certain other forms of health coverage, including employer coverage, Medicaid that

[14] The five years of continuous residence may begin prior to the date that the lawful admission for permanent resident is granted. See SSA POMS HI 00805.005 at https://secure.ssa.gov/poms.nsf/lnx/0600805005 and SSA POMS GN 00303.800 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0200303800.

includes immunosuppressive drugs, and Marketplace coverage.

Individuals can enroll in Part B-ID by calling SSA at 1-877-465-0355 or completing the CMS Form 10798 and mailing it to SSA. Medicare enrollment periods do not apply to Part B-ID so individuals can enroll in the benefit at any time.

For more information about the Part B-ID benefit, see section 40.9 of the Medicare General Information, Eligibility and Entitlement Manual at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/ge101c02.pdf; SSA POMS HI 00805.400 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600805400.

1.3.5 Medicare Enrollment

(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

In the absence of a buy-in agreement, individuals may only sign up for premium Part A or Part B during a prescribed Medicare enrollment period (i.e., their IEP, the GEP or an SEP for which they are eligible). Individuals can first sign up for premium Part A or Part B during their IEP. If they miss the IEP, they can enroll during the annual GEP but may pay a premium increase for late enrollment. For an explanation of the premium increase for Part B and premium Part A, see section 1.1. Individuals who qualify for an SEP can enroll in Medicare without having to wait for the GEP and are usually not subject to a late enrollment penalty (LEP).

Medicare enrollment periods do not apply to premium-free Part A, or the Part B-ID benefit described in section 1.3.4. Some individuals are automatically enrolled in Medicare, while others have to file for it, as described in section 1.3.5.1.

1.3.5.1 Medicare Enrollment Table

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

Automatic Enrollment	Individual Enrollment[15]
Premium-free Part A: Individuals automatically get premium-free Part A if they are: • Age 65 and over and receive Social Security or RRB retirement benefits; or • Under age 65 who receive Social Security or RRB disability benefits for 24 months. These individuals will also automatically get Part B if they live in the U.S., the Northern Mariana Islands, the U.S. Virgin Islands, Guam, or American Samoa. Individuals can choose to subsequently decline Part B. **Part B:** During their IEP for Part B, CMS mails the individual a welcome packet that contains background information and a Medicare card with the Part A and B effective dates. The mailing informs the beneficiary that: They do not pay a premium for Part A, which will start on the coverage date on the card; and They do owe a premium for Part B but can decline Part B coverage by signing the back of the card and returning the card before the Part B effective date.	**Premium-free Part A:** Individuals can file for Medicare premium-free Part A at SSA if they are: • Age 65 and over and have not yet filed for Social Security or RRB benefits; • An individual who qualifies for Medicare on the basis of ESRD; or • A government employee age 65 and over who has paid the Medicare payroll tax for the required number of quarters. Individuals who file for Part A are enrolled in Part B unless they decline it. **Premium Part A:** Individuals who qualify for premium Part A (i.e. those who do not qualify for premium-free Part A) must apply for Medicare at SSA. They can enroll in Part B only or premium Part A and Part B. **NOTE**: An individual can enroll in Medicare Part B without enrolling in premium Part A. Conversely, an individual cannot enroll in premium Part A unless the individual is receiving Part B benefits or files an application to enroll. **Delayed Premium Part A and Part B:** Individuals who did not enroll in premium Part A or Part B during their IEP can enroll during the GEP or during an applicable SEP. **Part B-ID:** Individuals apply for Part B-ID through SSA. Medicare enrollment periods do not apply to Part B-ID.

[15] An individual can sign up for Medicare Part A and Part B through SSA's toll-free number 1-800-772-1213, TTY 1-800-325-0778, by making an appointment at their local Social Security office, and with some exceptions, on the ssa.gov website. An individual can sign up for Part B-ID by calling SSA's toll-free number at 1-877-465-0355 and providing an oral attestation, or by mailing to SSA a completed Enrollment for Part B Immunosuppressive Drug Coverage Form CMS-10798, which is available at https://www.cms.gov/files/document/cms-10798.pdf.

1.3.6 Medicare Part A and Part B Re-enrollment
(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

An eligible individual who owes premiums from a past period of premium Part A or Part B coverage is permitted to re-enroll in Medicare. Although payment of past-due premiums is not a pre-requisite for re-enrollment, the individual is still liable for these amounts. See SSA POMS HI 01001.345 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0601001345. Individuals who reenroll can ask SSA about methods of payment and pursue options for financial relief that are described in section 1.15.2.

1.4 Requirements for Enrolling Individuals Under Buy-in Agreements
(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

1.4.1 General Requirements
(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

States must pay the Part A or B premiums for any individual who is both eligible to enroll in Part B and is determined eligible for a Medicaid eligibility group in the buy-in agreement. See sections 1843(a) and 1818(g) of the Act; 42 CFR 406.26 (a)(3) and 407.40(c)(1). A state cannot apply a "cost-effectiveness test" to choose individuals for buy-in (i.e., restrict buy-in to those who have incurred high medical expenses).

An individual's enrollment under a buy-in agreement is involuntary. A beneficiary who is eligible for a Medicaid eligibility group that is covered under their state's buy-in agreement cannot voluntarily terminate state buy-in coverage. See sections 1843(a) and 1818(g) of the Act; 42 CFR 406.26(a)(3) and 407.40(c)(1).

States may not pay Medicare premiums using the state buy-in process for non-citizens who are ineligible for Medicaid benefits (e.g., individuals who qualify for health coverage funded solely by the state).

States must follow federal requirements defining an individual's buy-in coverage period, including effective (start) and termination (stop) dates, even if buy-in processing is delayed.

States with buy-in agreements must exchange buy-in enrollment data with CMS on a daily basis under 42 CFR 407.40(c)(4). See chapter 2 for information regarding state and CMS processes to start and end buy-in.

1.4.2 Medicare Enrollment Under a State Buy-Agreement
(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

States directly enroll individuals covered under their buy-in agreement into Medicare premium Part A and Medicare Part B at any time of the year, without regard for Medicare enrollment

periods or late enrollment penalties. See 42 CFR 406.26(a)(2) and (b)(2) and 407.40(c)(1). If an individual covered under the buy-in agreement is already enrolled in either Medicare Part A or Part B, the state should directly enroll the individual in buy-in and refrain from referring the individual to SSA to apply for Medicare. See section 1.10 for more information.S

1.4.3 Limitations on State Liability for Retroactive Part B Premiums
(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

In some instances, SSA determines full-benefit Medicaid beneficiaries[16] eligible for Medicare for a retroactive period.[17] If a state learns that SSA established retroactive Medicare Part A entitlement for a full-benefit Medicaid beneficiary, the state must review the individual's eligibility for Part B buy-in over the retroactive period.

Starting January 1, 2024, state liability for retroactive Medicare Part B premiums for such individuals is limited to a period no greater than 36 months prior to the date of the Medicare enrollment determination. See 42 CFR 407.47(f). States can request a good cause exception from CMS for retroactive periods of less than 36 months if the state could not benefit from Medicare (e.g., based on the state's Medicaid recoupment policy) and limiting state liability would not result in harm to the beneficiary. States or beneficiaries can also request a good cause exception for retroactive periods of more than 36 months if the 36-month limit would result in harm to the beneficiary. See section 1.13.1 for more information on limitations on retroactive Part B buy-in liability for full-benefit Medicaid beneficiaries.

1.4.4 Medicaid Eligibility Redeterminations
(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

Eligibility for or enrollment in Medicare constitutes "a change in circumstances" that may affect a Medicaid beneficiary's eligibility, either by making them eligible for an additional eligibility group (such as a Medicare Savings Program group) or rendering them ineligible for their existing eligibility group (such as the "adult group" described at 42 CFR 435.119).[18] When a state

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[16] ''Full-benefit'' Medicaid coverage, in the context of individuals who are considered dually eligible, generally refers to the package of services, beyond coverage for Medicare premiums and cost sharing, that certain individuals are entitled to under 42 CFR 440.210 and 440.330.

[17] Retroactive Medicare awards often occur when an individual under age 65 files a claim for disability benefits and receives a favorable SSDI award multiple years after the initial application. Because individuals entitled to SSDI benefits become entitled to premium-free Medicare Part A after 24 months, the individual becomes retroactively entitled to Medicare Part A if the individual's start date for SSDI benefits is older than 24 months. If an individual already has Medicaid when they are retroactively enrolled in Medicare Part A, the state can be liable for retroactive Part B premiums per the state buy-in agreement. Many (but not all) Medicaid beneficiaries who are retroactively enrolled in Medicare are SSI recipients.

[18] For more information, see "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements," CMS Information Bulletin, December 4, 2020, at https://www.medicaid.gov/federal-policy-

anticipates or receives information that a current Medicaid beneficiary is newly eligible for Medicare, the state must promptly redetermine the individual's eligibility as required any time a Medicaid beneficiary experiences a change in circumstances that may impact Medicaid eligibility. See 42 CFR 435.916(d). If the state confirms that an adult group beneficiary is eligible for Medicare, the state may not terminate the individual's eligibility for the group until the state has first determined whether the individual is eligible for any other eligibility group. See 42 CFR 435.916(f)(1).

When the state has considered eligibility on all bases, the state must either move the beneficiary to the appropriate eligibility group if Medicaid eligibility continues or provide the individual advance notice and hearing rights in accordance with 42 CFR 435.917 and 42 CFR part 431, subpart E prior to terminating coverage. Note: the state must provide the beneficiary advance notice and hearing rights if the state determines the individual ineligible for the adult group due to Medicare eligibility and only alternatively eligible for an MSP group.

Additionally, the state must maintain the beneficiary's scope of medical assistance at least until it has provided the appropriate notice; e.g., if a state determines an adult group beneficiary who becomes eligible for Medicare ineligible for any other full-benefit Medicaid eligibility group or only eligible for an MSP group, the state must continue providing adult group coverage to the individual at least until the state has notified them of its determination and informed them of their fair hearing rights. See 42 CFR 431.230.

If the state determines the individual eligible for a Medicaid eligibility group included in the state's buy-in group, the state must start paying their Part A and/or B premiums. If a state that includes all Medicaid eligibility groups in its Part B buy-in coverage group has not completed the eligibility redetermination for an adult group beneficiary before the first month they qualify for Medicare, the state must enroll the individual in Part B buy-in for all months in which the individual is enrolled in the adult group following Medicare entitlement.

1.5 Effect of Buy-in on an Individual

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

If a Medicaid-eligible individual who is enrolled in an eligibility group included in a state's buy-in agreement is eligible for Medicare but not currently enrolled in it, state buy-in enrolls the individual in Medicare, providing access to Medicare-covered items and services.

NOTE: If an individual did not enroll in premium Part A or Part B during their IEP, or

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guidance/downloads/cib120420.pdf. By June 3, 2027, states must comply with new 42 CFR 435.919 (revised and redesignated certain requirements in 42 CFR 435.916) related to promptly acting on changes in circumstances and scope of redeterminations based on changes in circumstances. See April 2, 2024, Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes Final Rule (89 FR) 22789) at https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health.

previously withdrew from the programs, Medicare entitlement will be established or re-established effective with the first month that the individual becomes eligible for state buy-in.

If an individual is already enrolled in Medicare, state buy-in means the state will assume payments for the beneficiary's Medicare Part A and/or B premiums or Part B-ID premiums.

- If SSA deducts Medicare premiums from a beneficiary's Social Security benefit (OASDI), the deductions will stop, resulting in the beneficiary receiving a higher monthly payment.

- If CMS directly bills the beneficiary for Medicare premiums, such billing will end.

Once buy-in coverage is effective, the beneficiary shall receive a refund from SSA for any premiums (including any late enrollment penalties) that were deducted from the benefit amount or for premiums directly paid by the beneficiary to CMS, for any month the beneficiary is enrolled in state buy-in. Sometimes a state accretes a beneficiary to the state's buy-in account in error for months in which the individual was not eligible for a Medicaid eligibility group included in the buy-in agreement. In these instances, the beneficiary is entitled to keep any premium refunds received. The state must treat the individual as if they are eligible and may not attempt to recoup these amounts from the beneficiary.[19]

NOTE: The refund of Medicare premiums is not countable income under supplemental security income (SSI) methodologies. See SSA POMS SI 00815.050.B.2 at https://secure.ssa.gov/poms.nsf/lnx/0500815050 and SI 00815.400.A at https://secure.ssa.gov/poms.nsf/lnx/0500815400.

As a result, Medicaid agencies cannot consider the refund as income when determining eligibility for individuals whose Medicaid eligibility is based on SSI methodologies.

1.6 Part B Buy-in Coverage Groups in the 50 States and the District of Columbia - General

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

[19] Recovery of an "overpayment" made to beneficiaries is considered to be a retroactive termination of Medicaid eligibility. Retroactive termination of eligibility is prohibited by regulations at 42 CFR 431.211 to 431.214, which require states to provide at least ten days advance notice of a termination of eligibility in most situations; in a few discrete situations, termination on the date of action is allowed. Retroactive terminations of eligibility would also violate a beneficiary's due process rights under the U.S. Constitution and associated case law.
States are required to provide Medicaid to eligible state residents under 42 CFR 435.403(a) and must continue to furnish Medicaid to all eligible individuals until they are found to be ineligible pursuant to 42 CFR 435.930(b). When a state receives information that suggests a beneficiary is not eligible for Medicaid, the state must promptly conduct a redetermination of eligibility for that beneficiary. See 42 CFR 435.916(d)(1). This includes providing the beneficiary with an opportunity to demonstrate that the information the state received is not accurate or that the individual otherwise remains eligible for coverage. See 42 CFR 435.952(d). If the redetermination results in a finding of ineligibility for the beneficiary, the state may terminate eligibility provided that the beneficiary is afforded advance notice and hearing rights in accordance with 42 CFR part 435, subpart J and 42 CFR part 431, subpart E.

Federal law allows the 50 states and the District of Columbia to select one of three Part B buy-in coverage groups. See section 1843 of the Act; 42 CFR 407.42.[20]

The buy-in coverage groups are listed below, in order of narrowest to broadest.

- Group One: Cash Assistance Recipients and Deemed Recipients of Cash Assistance (Section 1.6.1)
- Group Two: Cash Assistance Recipients and Deemed Recipients of Cash Assistance Plus Three Medicare Savings Program (MSP) Groups (Section 1.6.2); and
- Group Three: All Medicaid Eligibility Groups (Section 1.6.3)

As of January 1, 2024, all states and the District of Columbia, and certain territories have buy-in agreements that include Part B buy-in for either (a) the cash assistance recipients and deemed recipients of cash assistance plus three MSP groups or (b) all Medicaid eligibility groups. Appendix 1.D classifies the Part B buy-in coverage groups in the 50 states, the District of Columbia, and specified U.S. territories.

Individuals may be eligible for one or more Medicaid eligibility groups in the buy-in agreement.

NOTE: Part B buy-in coverage groups must include SSI/State Supplement Programs (SSPs) recipients and deemed recipients of SSI/SSPs who qualify for Medicaid based on receipt (or deemed receipt) of such cash assistance.

1.6.1 Buy-in Coverage Group One: Cash Assistance and Deemed Recipients of Cash Assistance

(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

This buy-in group includes only individuals who are covered under the state plan as categorically needy and are cash assistance recipients or are deemed to be cash assistance recipients for the purposes of the Medicaid eligibility determination. This group includes Medicaid beneficiaries who are:[21]

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[20] When states could first enter into buy-in agreements in July 1966, they could choose between two Part B buy-in groups: 1) individuals receiving federally aided cash assistance; or 2) all Medicaid beneficiaries. After numerous changes, federal law allows states to select one of the three buy-in groups outlined in this section.

[21] SSA notifies Medicaid agencies of individuals who are determined eligible for SSI (and SSPs, in some cases) and may qualify for Medicare through the SSA systems such as the State Data Exchange (SDX). See section 2.4 for more information about SSA data sharing with states.

- SSI recipients;
- State Supplement Payment (SSP) recipients; and
- Deemed recipients of SSI/SSP and the former Aid to Dependent Children and Families (AFDC) Program.

1.6.1.1 Supplemental Security Income (SSI) Program Recipients
(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

SSI is a federal cash assistance program that serves low-income individuals who are age 65 or older or have blindness or a disability. SSI recipients typically qualify for other state and federal programs, including Medicaid and Medicare.

1.6.1.2 Full-benefit Medicaid Eligibility for SSI Recipients
(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

In most states, the receipt of SSI is a mandatory basis for Medicaid eligibility. See section 1902(a)(10)(A)(i)(II)(aa) of the Act; 42 CFR 435.120 ("Individuals receiving SSI group" (also known as the "mandatory SSI group")). As of January 1, 2024, 33 states and the District of Columbia that cover the mandatory SSI group have an agreement with SSA under which SSA determines eligibility for the mandatory SSI group, and the Medicaid agency automatically enrolls in Medicaid those individuals who SSA has determined to be eligible for SSI. These agreements are authorized under section 1634 of the Act, and states that have entered into such agreements with SSA are commonly referred to as "1634 states."

Nine states that cover the mandatory SSI group apply the SSI income and resource methodologies and disability criteria in determining Medicaid eligibility but require SSI recipients to file a Medicaid application with the state Medicaid agency to establish their Medicaid eligibility ("SSI criteria states").

Eight states do not cover the mandatory SSI group. Instead, these states have elected the option to apply financial methodologies more restrictive than SSI in determining Medicaid eligibility for individuals age 65 or older, or who have blindness or disability, subject to certain conditions. See section 1902(f) of the Act; 42 CFR 435.121 (Individuals in states using more restrictive requirements for Medicaid than the SSI requirements.) These states are referred to as "209(b)" states, after the provision of the Social Security Act Amendments of 1972, Pub. L. No. 92- 603, section 209(b), which enacted what became codified at 1902(f) of the Act.

1.6.1.3 Part B Buy-in for SSI Recipients
(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

In addition to having Medicaid, many SSI recipients are entitled to Medicare Part A and/or

enrolled in Part B. In 1634 states, once SSA has determined an individual eligible for the mandatory SSI group and Part B, CMS will initiate, on behalf of the state, Part B buy-in for individuals. For the purposes of Part B buy-in, CMS refers to 1634 states as SSI "auto-accrete" states. In SSI criteria and 209(b) states, CMS does not auto-enroll SSI recipients in Part B buy-in since they must separately apply for Medicaid. Instead, once SSA determines an individual eligible for SSI and Part B, CMS sends an "alert" to the state to initiate Part B buy-in for the individual if they are eligible for Medicaid. For the purposes of Part B buy-in, CMS refers to SSI criteria and 209(b) states as "alert states."

Appendix 1.D classifies states by whether they are an auto-accrete or alert state (including SSI criteria and 209(b)) as of January 1, 2024. See section 2.5.1 for more information about buy-in enrollment processes in auto-accrete and alert states.

1.6.1.4 Qualified Medicare Beneficiary Group Eligibility for SSI Recipients
(Rev. 6; **Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)**

In addition to qualifying for Medicaid and Part B buy-in, SSI recipients are always financially eligible for the QMB eligibility group, which covers Medicare Parts A and B premiums and cost-sharing. Effective October 1, 2024, CMS regulations at 42 CFR 435.909(b) require states to automatically enroll in the QMB eligibility group most individuals determined eligible for Medicare and the mandatory SSI group or mandatory 209(b) group ("SSI-based Medicaid").

See section 1.6.2.6 for a description of these requirements.

1.6.1.5 State Supplement Programs (SSPs) Recipients
(Rev. 6; **Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)**

Most states operate their own cash assistance programs—known as optional SSPs—for people who are 65 years old and older, or who have blindness or disability. Payments from these programs are not counted as income under the SSI program. In many cases, these benefits supplement the SSI benefits an individual receives.[22] In other cases, individuals receive only an SSP payment if they would otherwise meet the requirements for SSI but for having too much income. States have the option to extend categorical Medicaid eligibility to individuals who are not eligible for SSI, but who receive an SSP benefit.

Similar to the authority provided by section 1634 of the Act for states to enter agreements with SSA for SSA to determine Medicaid eligibility of SSI applicants, section 1616 of the Act authorizes states to enter agreements with SSA in which SSA determines SSP program eligibility ("1616 agreements"). In such states, an application for SSI is also an application for SSPs. Other states perform determinations for SSPs themselves. See SSA POMS SI 01401.001 at

[22] States in which the grant-in-aid cash benefit rate in December 1973 exceeded the SSI Federal Benefit Rate of January 1974 are required to pay a supplement to beneficiaries to make up the difference. Individuals who continue to receive these mandatory state supplements are mandatorily eligible for Medicaid. See 42 CFR 435.130. There are no new applicants for this eligibility group.

https://secure.ssa.gov/apps10/poms.nsf/lnx/0501401001.

1.6.1.6 Deemed Recipients of Cash Assistance

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

Buy-in can be applicable to two categories of deemed recipients of cash assistance: deemed SSI/SSP recipients and deemed AFDC recipients.

Over time, federal law has mandated that certain individuals who were at one point receiving cash assistance but who lost it due to increases in Social Security benefits (OASDI) be treated, for purposes of Medicaid eligibility, as if they continue to receive cash assistance, i.e., these individuals are "deemed" to be receiving SSI/SSPs. Federal law and regulations make these individuals mandatorily eligible for Medicaid.[23] States must include these individuals in state buy-in agreements.

Aid to Families with Dependent Children (AFDC) is a cash assistance program that was replaced by Temporary Assistance for Needy Families (TANF) in 1996.[24] No Medicaid state plan eligibility groups are linked to TANF; a few Medicaid eligibility categories, however, are linked to eligibility standards of the former AFDC program and offer eligibility to certain individuals who are "deemed" to meet such standards, as the program existed in 1996. Deemed AFDC recipients include individuals who receive adoption assistance, foster care, or guardianship care under Title IV-E of the Act, in accordance with 42 CFR 435.145, and low-income families described in section 1931(b)(1)(A) of the Act. Effective January 1, 2023, states have the option to designate all deemed recipients of AFDC as cash assistance recipients with eligibility groups related to SSI/SSP, or to only cover individuals who receive or are deemed to receive SSI/SSP as cash assistance recipients in their Part B buy-in coverage group. See 42 CFR 407.42(b).

1.6.2 Buy-in Coverage Group Two: Cash Assistance Recipients and Deemed Recipients of Cash Assistance Plus Three Medicare Savings Program Groups

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

A second option for states to select for inclusion in their buy-in agreements is cash assistance recipients, deemed recipients of cash assistance and the three primary Medicare Savings Program (MSP) Medicaid eligibility groups. Preceding sections 1.6.1 through 1.6.1.3 describe the cash assistance and deemed cash recipients who are included in buy-in agreements for states selecting

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[23] The following categories are deemed recipients of SSI/SSPs: certain individuals who would have been eligible for cash assistance in 1972 but who lost it because of an increase in their OASDI benefits (42 CFR 435.134 and 435.112); certain individuals (sometimes known as "Pickle" individuals) who used to qualify for both SSDI and SSI but who no longer qualify for SSI because their income exceeds the SSI income limit (42 CFR 435.135);certain working individuals with disabilities who have become income-ineligible for SSI (section 1619(b) of the Act and 42 CFR 435.120(c)); certain disabled widow/ers (42 CFR 435.137 and 435.138); and certain adult children with disabilities (section 1634(c) of the Act).

[24] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. 104-193).

this coverage group. This section details the MSP groups that are included in this buy-in coverage group option.

In accordance with section 1902(a)(10)(E) of the Act, MSP eligibility groups are part of states' Medicaid programs and assist low-income individuals with their Medicare costs. The MSPs are Medicaid eligibility groups through which Medicaid covers Medicare Part A and/or B premiums and, for most enrollees, cost-sharing.

Starting January 1, 2023, section 402(f) of the CAA, 2021 expanded the primary MSPs to pay some or all of the costs of the new immunosuppressive drug coverage for certain low-income individuals who are enrolled in such drug coverage.

The MSPs include three primary Medicaid eligibility groups:

- Qualified Medicare Beneficiary (QMB) group
- Specified Low-Income Medicare Beneficiary (SLMB) group
- Qualifying Individual (QI) group.

Individuals may be eligible for an MSP alone (also known as "partial-benefit dually eligible individual") or may be simultaneously eligible for an MSP (QMB or SLMB) and a full-benefit Medicaid eligibility group under the state plan (also known as "full-benefit dually eligible individual").

As noted in section 1.6, all state buy-in agreements in the 50 states and the District of Columbia include the payment of Part B premiums for QMBs, SLMBs, and QIs.

NOTE: A fourth, and much smaller MSP eligibility group is the Qualifying Disabled Working Individuals (QDWI) group. Eligibility for the QDWI group, as described in sections 1902(a)(10)(E)(ii) and 1905(s) of the Act and 42 CFR 435.126, is limited to individuals under age 65 with disabilities who:

- are eligible to enroll in premium Part A once premium-free Part A expires following a return to work (see section 1.3.2 for more information on premium Part A eligibility);
- have income that does not exceed 200 percent of the FPL;
- have resources that do not exceed twice the relevant SSI resource standard (i.e., for a single individual or couple); and
- are otherwise ineligible for Medicaid benefits.

Individuals with disabilities who return to work may qualify for full-benefit Medicaid coverage (e.g. mandatory coverage for working individuals under 1619(b) of the Act or optional Medicaid

buy-in eligibility groups for working individuals with disabilities described in sections 1902(a)(10)(A)(ii)(XIII), (XV), and (XVI) of the Act), which makes them ineligible for the QDWI eligibility group. See sections 1.6.1.6 and 1.6.3 for information about Part B buy-in coverage for working individuals with disabilities who qualify for full-benefit Medicaid coverage.

States pay Part A premiums (but not Part B premiums) for QDWIs. States cannot include the Part A premium payments for QDWIs in their buy-in agreements. States pay the Part A premiums for QDWIs through the group payer process.

Sections 1.6.2.4 through 1.6.2.8 contain additional information about the QMB, SLMB, and QI groups.

For detailed information on dually eligible individual categories, including the degree to which individuals in each category receive assistance with Medicare Parts A and B premiums and cost-sharing, see appendix 1.A.

For more information about the buy-in start date for these categories, see sections 1.13 and 1.14, and appendix 1.C.

1.6.2.1 Medicare Savings Program Eligibility and Enrollment

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

Individuals typically apply for MSPs directly at their state Medicaid agencies. States must also:

- Deem most individuals who receive SSI and have Medicare and full-benefit Medicaid eligible for the QMB eligibility group as described in section 1.6.2.6; and
- Initiate an MSP application upon receipt of data from Part D Low-Income Subsidy (LIS) program applications (‘‘LIS leads data’’) from SSA as described in section 1.6.2.3.

Income and resources criteria: Federal statutes and rules set forth the applicable income and resource standards (“limits”) for each MSP group. See section 1902(a)(10)(E) of the Act; 42 CFR 435.123 through 126. In determining countable income and resources for MSP eligibility, states must use income and resource methodologies no more restrictive than the methodologies for the SSI program. See section 1905(p) of the Act; 42 CFR 435.601(b)(2). However, under section 1902(r)(2) of the Act, states have the flexibility to adopt income and resource methodologies less restrictive than the SSI program’s to effectively increase the QMB, SLMB and QI income and resource limits above the federal baseline and to remove the resource test altogether. [25]

[25] For more information on state flexibilities, see “Opportunities to Increase Enrollment in Medicare Savings Programs” CMS Information Bulletin, November 1, 2021, at https://www.medicaid.gov/federal-policy-

States that use section 1902(r)(2) authority to fully align their MSP income and resource methodologies with the LIS program methodologies can determine an individual's eligibility for the MSPs using LIS leads data, without requesting any financial information from the individual.[26]

Family of the size involved: The Social Security Act[27] sets forth income limits for the MSPs relative to the FPL "applicable to a family of the size involved." CMS has permitted states to apply their own reasonable definition of the phrase "family of the size involved."[28]

By April 1, 2026, states must apply a definition of "family of the size involved" in determining eligibility for the MSP groups that includes at least the individuals included in the definition of "family size" for the Part D LIS program described in 42 CFR 423.772. To effectuate this change, states must submit a State Plan Amendment (SPA).

See 42 CFR 435.601(e). The Part D LIS definition includes the applicant, the spouse who is living in the same household, if any, and the number of individuals who are related to the applicant or applicants, who are living in the same household and who are dependent on the applicant or the applicant's spouse for at least one half of their financial support.

COLA adjustments: States must adjust their eligibility standards to reflect the annual poverty level guidelines established at least annually by HHS upon their publication in the Federal Register. Additionally, states cannot count income attributable to a Social Security cost of living adjustment (COLA) as income for MSP eligibility purposes for individuals until the month following the month HHS publishes the new poverty level figures. See section 1905(p)(2)(D) of the Act; 42 CFR 435.123 through 435.126.

Verification of Income and Resources:

States must verify financial eligibility for the MSPs in accordance with sections 1137 and

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guidance/downloads/cib11012021.pdf. See also, "Improving Participation in the Medicare Savings Programs," Chapter 3 in June 2020 Report to Congress on Medicaid and CHIP, Medicaid and CHIP Payment and Access Commission (MACPAC) at https://www.macpac.gov/publication/chapter-3-improving-participation-in-the-medicare-savings-programs/.

[26] See final rule titled ''Streamlining Medicaid: Medicare Savings Program Eligibility Determination and Enrollment" published in the September 21, 2023 Federal Register (88 FR 65320, 65239) at https://www.govinfo.gov/content/pkg/FR-2023-09-21/pdf/2023-20382.pdf ("the September 21, 2023 MSP final rule"). States would only need to verify citizenship or immigration status obtain assignment of rights to medical support and third-party payers as described in section 1.6.2.3.

[27] See sections 1905(p)(2)(A) and (B) (the QMB group), 1902(a)(10)(E)(iii) and (iv) (the SLMB and QI groups respectively), and 1905(s)(2) (the QDWI group) of the Act.

[28] See Memorandum from Director, Center for Medicaid and State Operations, to Regional Administrator, re: Medicaid Eligibility—Policy Governing Family Size in Determining Eligibility for Qualified Medicaid Beneficiaries and Specified Low-Income Beneficiaries. October 2, 1997, at https://www.medicaid.gov/sites/default/files/2019-12/medicaid-eligibilty-memo.pdf.

1902(a)(46)(A) of the Act and 42 CFR 435.940 through 435.942 and 435.380. For resources held in financial institutions, states may either elect to accept self-attestation of resources or to use an Asset Verification System (AVS) for the MSPs. If a state does not accept self-attestation of resources that can be verified through AVS, the state cannot require individuals to provide proof of such resources without first attempting to verify them through AVS.[29]

Distinct requirements apply to the verification of certain income and resources for all MSPs applications (section 1.6.2.2) and to MSP applications the state receives from SSA through the LIS leads process (section 1.6.2.3).

Screen on all bases: State Medicaid agencies must generally determine an individual's eligibility for all Medicaid eligibility groups for which they may qualify. For Medicare beneficiaries, these include full-benefit Medicaid eligibility groups and the MSPs. Accordingly, states' eligibility system hierarchy should be programmed to reflect both MSP eligibility determinations as well as full-benefit Medicaid eligibility groups. Note that some states may have MSP-only applications that do not request the information necessary for categorical Medicaid determinations. Consistent with 42 CFR 435.911(c), by April 1, 2026, states must adhere to specific sequencing of eligibility determinations for individuals whose MSP applications originate with SSA transmittal of LIS leads data as described in CMS regulations at 42 CFR 435.911(e)(9) and section 1.6.2.3.

1.6.2.2 Verification of Certain Income and Resources for the Medicare Savings Programs

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

No later than April 1, 2026, states are required to implement enrollment simplification policies related to verification of certain income and resources that the MSPs count but LIS does not (i.e., interest and dividend income; non-liquid resources, and the cash value of certain whole life insurance policies). States must also simplify verification of burial funds, which the MSPs count differently than does LIS.

NOTE: The requirements below apply to all MSP applications, regardless of whether the individual initiates the application by directly applying to the state Medicaid agency or the state receives the application from SSA through the LIS leads process. Also, if CMS conducts audits related to state MSP eligibility determinations, CMS will not identify an error if the state follows these requirements.

Interest and dividend income and non-liquid resources: States must accept self-attestation of the value of any: 1) dividend and interest income earned by the applicant or the applicant's

[29] See "Financial Eligibility Verification requirements and Flexibilities," CMS Informational Bulletin, November 20, 2024, at https://www.medicaid.gov/federal-policy-guidance/downloads/cib11202024.pdf.

spouse and 2) non-liquid resources owned by the applicant or the applicant's spouse. 42 CFR 435.952(e)(1) and (e)(2). States may not request documentation of the attested value prior to determining MSP eligibility unless the state agency has information that is not reasonably compatible with an applicant's attestation. In that case, the agency must seek additional information from the individual, which may include a reasonable explanation of the discrepancy or documentation. See 42 CFR 435.952(c)(2).

States have the option to conduct post-enrollment verification of interest and dividend income and/or non-liquid resources after the individual has been determined eligible for an MSP, as described below.

Burial funds: States must allow individuals to self-attest that up to $1,500 of their resources, and up to $1,500 of their spouse's resources, are set aside as burial funds in a separate account (regardless of whether they are revocable or irrevocable accounts). See 42 CFR 435.952(e)(3). States may not request documentation of the attested amount prior to determining MSP eligibility unless the state agency has information that is not reasonably compatible with an applicant's attestation. In that case, the agency must seek additional information from the individual, which may include a reasonable explanation of the discrepancy or documentation. See 42 CFR 435.952(c)(2).

States have the option to conduct post-enrollment verification of burial funds after the individual has been determined eligible for an MSP, as described below.

Life insurance policies: If the total face value of all of an individual's life insurance policies does not exceed $1,500, the cash surrender value of the individual's policies is not counted in determining MSP eligibility.

If an individual attests to having a life insurance policy with a *face value* below $1,500, states must accept the attested face value for purposes of making an initial eligibility determination for MSP coverage, unless the state has information that is not reasonably compatible with the attested information. In that case, the agency must seek additional information from the individual, which may include a reasonable explanation of the discrepancy or documentation. See 42 CFR 435.952(c)(2).

If an individual attests to a face value of a life insurance policy that is above $1,500, the state may also accept their attestation of the cash surrender value of the life insurance policy. If the agency has information about the cash surrender value of a life insurance policy that is not reasonably compatible with the applicant's attestation, the agency must seek additional information from the individual, which may include a reasonable explanation of the discrepancy or documentation. See 42 CFR 435.952(c)(2).

If the state accepted an individual's self-attestation of the face value or cash surrender value of a life insurance policy, the state also has the option to conduct post-enrollment verification as described in this section below.

If the state requires documentation of the cash surrender value of a life insurance policy -- either prior to enrollment or during post-enrollment verification -- the state must assist the individual with obtaining this information and documentation. This requires requesting that the individual provide the name of the insurance company and policy number and authorize the state to obtain documentation of the cash surrender value on the individual's behalf. The state agency may also request, but may not require, additional information from the applicant, such as the name of an agent.

If the individual does not provide basic information about the policy and an authorization, the state may require that the individual provide documentation of the cash surrender value within at least 15 calendar days. See 42 CFR 435.952(e)(4).

Post eligibility verification: States that accept an individual's attestation for the income and resource categories described above have the option to conduct post-enrollment verification. If the agency requests information post-enrollment, it must allow the individual at least 90 days from the date of the request to provide any necessary information requested and must allow the individual to submit such documentation through the internet, by telephone, in person or through other commonly available electronic means. 42 CFR 435.952(e)(1)(iii); (e)(2)(iii) and (e)(3)(iii) and (e)(4)(iii); and 435.907(a).

States may not administratively recoup payments already made on behalf of individuals if post-enrollment verification processes establish that the individual is ineligible for the MSPs. If a state suspects that an individual committed fraud or abuse in order to obtain or maintain MSP eligibility, the state should follow the processes described at 42 CFR part 455, subpart A of the regulations.

1.6.2.3 Medicare Savings Programs Determinations Based on Part D Low-Income Subsidy (LIS) Leads Data

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

Since January 1, 2010, federal law has required SSA to transmit to states data from LIS applications processed by SSA ("LIS leads") and has required states to treat the data as an application for the MSPs. See sections 1144(c)(3) and 1935(a)(4) of the Act. For additional information about LIS leads data, see section 2.4.2.5.

States must treat the date the individual files the LIS application with SSA as the date of application for purposes of establishing the effective date of eligibility for MSP benefits. When calculating the 45 day timeliness standard as described under 42 CFR 435.912(c), states may either use the date that the state receives the LIS leads data from SSA or the date of the LIS application as the start of the calculation.[30] CMS regulations at 42 CFR 435.911(e) require states

[30] See September 21, 2023 MSP final rule (88 FR 65320, 6532) at https://www.govinfo.gov/content/pkg/FR-2023-09-21/pdf/2023-20382.pdf; February 18, 2010 State Medicaid Director Letter (SMDL #10–003), ''Medicare

to take specific actions on MSP applications based on the receipt of LIS leads data.

Also, if CMS conducts audits related to state MSP eligibility determinations, CMS will not identify an error if the state follows these requirements.

No later than April 1, 2026, the states must have procedures in place to meet all of the following requirements:

1. Treat the LIS leads data as an application for MSPs without requiring submission of another application.

NOTE: On rare occasions, a state may receive an LIS leads file for an individual who did not complete the entire LIS application (https://www.ssa.gov/forms/ssa-1020b-ocr-sm-inst.pdf), because they answered "yes" on question 3, indicating they have resources that exceed the LIS resource limit. If a state receives such a LIS leads file, it means the individual also answered "yes" on the question 15, requesting that the state nevertheless screen them for the MSPs. States must therefore treat the receipt of such LIS leads data as an application for MSPs. The leads data will not contain income and resources information, so the state must reach out to the individual to obtain missing information that is necessary for the MSP determination (see #4).

2. Accept LIS leads data without further verification and not require additional verification or documentation unless (1) the income or resources in the leads data are over the applicable MSP income and resource limits data and, therefore, do not support a finding that the individual is eligible for an MSP (see #6 below); or (2) the agency is aware of information that is not reasonably compatible with the leads data. See 42 CFR 435.911(e)(4).

NOTE: The LIS leads data record layout (https://www.ssa.gov/dataexchange/documents/LIS%20record.pdf) describes each LIS income and resource data element, including whether the amount reflected incorporates standard SSI exclusions. If the income or resource data element does not include the standard SSI exclusions, the state must apply all applicable exclusions prior to completing the eligibility determination. In addition, if the state's approved Medicaid state plan disregards certain amounts or types of income or resources under section 1902(r)(2) of the Act for the MSP groups, the state must apply all applicable disregards prior to completing the eligibility determination.

The LIS leads data elements for *unearned* income and resources (except burial funds) show combined total amounts for the applicant and spouse if living together. Under SSI methodologies, the income and resources of an individual and their spouse (if their spouse is not eligible for SSI as defined in 20 CFR 416.2260(d) ("ineligible spouse")) are countable. As such, states should deem the combined amounts of unearned income and resources in the LIS leads data to the applicant instead of requesting additional information unless certain conditions exist. If the LIS leads data indicate that *EITHER:*

Improvements for Patients and Providers Act of 2008 (MIPPA),''https://www.medicaid.gov/federal-policyguidance/downloads/smd10003.pdf.

- the individual has a spouse who is eligible for SSI (an "eligible spouse");

OR

- the state applies less restrictive methodologies than SSI under section 1902(r)(2) of the Act for all or a portion of an applicant's spouse's unearned income or resources;

AND the LIS data indicate that EITHER:

- the individual would be ineligible for the QMB group but eligible for the SLMB or QI group, in which case the state should request ownership information. If the applicant does not provide the ownership information and the state has the information needed to determine eligibility for the SLMB or QI groups, the state must approve eligibility for the SLMB or QI groups;

  OR

- the individual would be ineligible for an MSP, in which case the state would reach out to the individual as required by 42 CFR 435.911(e)(8) (see #6).

3. Not request information or documentation from the individual that SSA has already provided through the LIS leads data unless the agency has information that is not reasonably compatible with the leads data.

4. Seek additional information that is necessary for an MSP eligibility determination but that the LIS leads data does not contain. Prior to completing the MSP eligibility determination states must request additional information from the individual to:

a. Obtain information for certain income and/or resources if the state has not aligned its methodologies for them with LIS through the election of 1902(r)(2) disregards in its Medicaid State Plan. (As compared to methodologies used by SSI, LIS does not count in-kind support and maintenance, interest and dividend income, non-liquid resources, and the cash value of life insurance. While SSI methodologies disregard up to $1,500 of burial funds only if they are set aside in a separate account, LIS disregards up to $1,500 of burial funds even if they are comingled with other funds).

b. Verify the individual's U.S. citizenship or satisfactory immigration status. In accordance with 42 CFR 435.406(a) and section 1137(d) of the Act, the state must request the individual complete a declaration of U.S. citizenship or satisfactory immigration status. If the individual returns a signed declaration to the state, requirements to verify the declaration are as follows:

- **US citizens:** When a Medicare beneficiary returns a declaration of U.S. citizenship, the state is not required to undertake further steps to verify citizenship status. See section 1903(x) of the Act and 42 CFR 435.406(a)(1)(iii). Since LIS requires Part A or Part B enrollment, the vast majority of LIS applicants are Medicare beneficiaries. In the rare instance the LIS data shows an individual is not a Medicare beneficiary, the state would need to verify U.S. citizenship status.

- **Noncitizens:** States must verify the applicant's declaration of satisfactory immigration status per 42 CFR 435.956 unless:

  - the state has previously verified this information, and it's included in the individual's case record;
  - the individual has not reported a change, and
  - the agency has not received information indicating a potential change.

c. Obtain assignment of rights to medical support and third-party payers since the LIS application does not contain this information. States with automatic assignment laws do not need to obtain an executed assignment of rights and can instead inform the individual of the terms and consequences of the state law. See 42 CFR 433.146; https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/training-and-handbook_256.pdf.

5. Determine the eligibility of the individual for MSP promptly and without undue delay, consistent with timeliness standards established under 42 CFR 435.912.

6. If the income and resource information in the LIS leads data shows the individual is above the MSP income and resource limits, the state may not complete an eligibility determination without further steps. The state must:

a. Determine what additional information the state needs to make an MSP eligibility determination and notify the individual, providing a minimum of 30 days to furnish any needed information.[31]

b. Verify the individual's eligibility for MSP in accordance with the agency's verification plan developed in accordance with 42 CFR 435.945(j).

7. In addition to and separate from any requests for additional information necessary for a determination of MSP eligibility (and unless CMS approves otherwise), provide the individual with information about the availability of additional Medicaid benefits on other bases, and an opportunity to furnish such additional information as may be needed to

[31] The notice must tell the individual that they may be eligible for assistance with their Medicare premium and/or cost sharing charges, but that the state needs additional information to determine such eligibility.

determine the individual's Medicaid eligibility.[32]

1.6.2.4 Qualified Medicare Beneficiary Group

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

Under the QMB Medicaid eligibility group, states cover the Medicare Parts A and B premiums and cost-sharing (i.e., deductibles, coinsurance, co-payments,[33] and at state option, Part C premiums) for individuals who:

- Meet one of the following conditions:
    - Are entitled to Medicare Part A (including premium-free Part A and premium Part A for certain individuals age 65 and over who need to pay a premium to enroll in Part A);[34]
    - For those without Part A, depending on the state have:
        - Part B only; or
        - Part B and conditional Part A
- Have income that does not exceed 100 percent of the FPL; and
- Have resources that do not exceed three times the maximum resource level under the SSI program, adjusted for inflation per section 1905(p)(1) of the Act.[35]

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[32] The notice must provide the scope of such benefits and responsibilities of the individual applying for such benefits.

[33] Note that Medicare providers cannot charge QMBs for Medicare deductibles, coinsurance, and copays – even if the individual agrees to pay them. See https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf.

[34] Under section 1905(p)(1)(A) of the Act and 42 CFR 435.123, QMBs must either be entitled to premium-free Part A, entitled to premium Part A for individuals age 65 and over, or, on or after January 1, 2023, enrolled in Part B-ID. Individuals are not eligible for the QMB group if they are entitled to Part A based on 42 CFR 406.20(c) (Premium Part A for individuals with disabilities who have lost SSDI and subsequently premium-free Part A after returning to work).

[35] Effective January 1, 2010, section 1905(p)(1) of the Act provides that the resource limit is three times the SSI limit adjusted annually by increases in the Consumer Price Index. Note that the full LIS program and the QMB, SLMB and QI groups used the same resource standard through December 31, 2023. Beginning January 1, 2024, section 11404 of the Inflation Reduction Act of 2022 (Pub. L. 117–169) increased the income limit for the full LIS program to income below 150 percent of the FPL and increased the resource limit to the resource limit that previously had been applied to the partial LIS program. See 42 CFR 423.773(b)(1) and (b)(2). Note also that several states have effectively increased income limits and/or increased or eliminated resource limits for their MSPs.

Starting January 1, 2023, section 402(f) of the CAA, 2021 expanded the QMB eligibility group to cover the premiums and cost-sharing for Part B-ID immunosuppressive drug coverage (QMB Part B-ID) for individuals who:

- Are enrolled in Part B-ID and
- Meet the QMB income and resource limits described above.

See sections 1902(a)(10)(E)(i) and 1905(p) of the Act; 42 CFR 435.123. Current minimum federal income and asset limits for the QMB eligibility group are available at https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html. As described in section 1.6.2.1, states can modify their financial eligibility methodologies to effectively increase the income or resource standard above the federal floor.

NOTE: The majority of individuals who qualify for QMB also qualify for a separate Medicaid eligibility group that entitles them to the full range of services provided under the state plan, in addition to Medicare cost-sharing assistance.[36] These individuals are referred to as QMB plus. Individuals who do not also qualify for full-benefit Medicaid are referred to as QMBSonly.

1.6.2.5 Effective Date of Qualified Medicare Beneficiary Group Coverage

(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

Under section 1902(e)(8) of the Act, QMB enrollment is effective the month following "the month in which the [QMB] determination first occurs." States have flexibility in applying this provision. States can choose to define the month in which the QMB determination first occurs for the QMB coverage group as either: (1) the month that the applicant meets all requirements for QMB or (2) the month in which the eligibility determination is made (if those months are different).

For example, if an individual applies for Medicaid on January 1, and on February 15 the state determines the individual met all of the requirements of QMB in January, the state may either begin QMB coverage on February 1 (i.e., if state elects option one above) or March 1 (i.e., if the state elects option two above).

For QMB-plus individuals determined eligible at application, the separate full-benefit Medicaid coverage may be effective up to three months before the month of application, if the individual received Medicaid covered services and would have been eligible at the time the services were received, even though the same retroactive eligibility period does not apply to their QMB benefits. See 42 CFR 435.915(a).

For information about the QMB effective date applicable to individuals who lack premium-free

[36] In 2022, 79 percent of QMBs qualified for full-benefit Medicaid in addition to QMB ("QMB-plus"), while 21 percent of QMBs qualified for QMB alone ("QMB-only").

Part A and reside in a group payer state, as required by CMS regulations at 42 CFR 406.21(c)(5), see section 1.11.

1.6.2.6 Automatic Enrollment of SSI Recipients into the Qualified Medicare Beneficiary Group

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

Regulations at 42 CFR 435.909(b) require states take the following steps to automatically enroll SSI recipients in the QMB group. No later than October 1, 2024:

- **All states:** Deem individuals determined eligible for the mandatory SSI or mandatory 209(b) state group ("SSI-based Medicaid") eligible for the QMB **group if they are entitled to premium-free Part A**. Start Part B buy-in coverage the first month they are entitled to premium-free Part A and receiving SSI-based Medicaid and start QMB group coverage the first day of the following month.

  Example: if an individual is first enrolled in SSI-based Medicaid and entitled to premium-free Part A in January 2025, the state would start paying the individual's Part B premiums under the buy-in agreement and deem the individual eligible for the QMB group in January 2025. The individual's QMB group coverage (including Medicare cost-sharing coverage) would start February 1, 2025.

- **Part A buy-in states**: Deem individuals who have SSI-based Medicaid as eligible for the QMB group **if they lack premium-free Part A and are enrolled in Part B only.** Start Part B buy-in coverage the first month they are enrolled in Part B and receiving SSI-based Medicaid and start QMB coverage (including Part A buy-in and Medicare cost-sharing coverage) the first day of the following month.

  Example: if an individual is first enrolled in both SSI-based Medicaid and Part B only in January 2025, the state would start paying the individual's Part B premiums under the buy-in agreement and deem the individual eligible for the QMB group in January 2025. The individual's QMB group coverage (including Part A buy-in and Medicare cost-sharing coverage) would start February 1, 2025

  See sections 1.10 and 1.11 for more information about QMB enrollment for individuals who lack premium-free Part A and reside in Part A buy-in states.

Option for group payer states to automatically enroll certain SSI recipients into QMB: As described in section 1.11, individuals in group payer states who lack premium-free Part A generally must enroll in premium Part A or conditional premium Part A at SSA during a Medicare enrollment period prior to applying for QMB at their Medicaid agency. The regulation at 42 CFR 435.909(b)(2) provides an exception to this requirement for individuals who:

- have SSI-based Medicaid;

- lack premium-free Part A; AND
- are enrolled in Part B only.

The regulation permits group payer states to deem these individuals (who have SSI-based Medicaid, lack premium-free Part A, and are enrolled in Part B only) as eligible for the QMB group the first month they are both enrolled in Part B and eligible for a Medicare enrollment period. To request this option to bypass the need for premium or conditional premium Part A enrollment at SSA, email ModernizetheMSPs@cms.hhs.gov.

***Ex Parte* Renewals in 1634 states:** During an *ex parte* renewal for an individual eligible under both the mandatory SSI and QMB groups, to renew their eligibility in both groups, states need only verify that the individual still:

a. receives SSI (i.e., the state has not received data from SSA indicating a loss of SSI status) and
b. is entitled to Medicare Part A (i.e., the state has not received data from SSA/CMS indicating a loss of Part A)

1.6.2.7 Specified Low-Income Medicare Beneficiary Group

(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

Under the SLMB Medicaid eligibility group, state Medicaid programs pay the Medicare Part B premiums for individuals who:

- Are entitled to Medicare Part A (including individuals age 65 and over who are only entitled to premium Part A);
- Have income that exceeds 100 percent but is less than 120 percent of the FPL; and
- Have resources that do not exceed three times the maximum resource level under the SSI program, adjusted for inflation per section 1905(p)(1) of the Act.

Starting January 1, 2023, section 402(f) of the CAA, 2021 expanded the SLMB eligibility group to cover the premiums for Part B-ID immunosuppressive drug coverage (SLMB Part B-ID) for individuals who:

- Are enrolled in Part B-ID and
- Meet the SLMB income and resource limits described above.

See sections 1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act; 42 CFR 435.124.

Current federal income and asset limits for SLMB are available at

https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees. As described in section 1.6.2.1, states can modify their financial eligibility methodologies and requirements above the federal floor.

Unlike QMBs, the state is precluded from paying the Medicare Part A premiums for SLMBs. Some individuals who qualify for SLMB also qualify for a separate Medicaid eligibility group that entitles them to the full range of services provided under the state plan, in addition to assistance with the Medicare Part B premium.[37]

SLMBs who also qualify for full-scope Medicaid are referred to as SLMB-plus and those who do not are SLMB-only.

Coverage for an individual determined eligible under the SLMB group may be effective up to three months before the month of application if the individual received Medicaid covered services and would have been eligible at the time services were received. See 42 CFR 435.915(a).

1.6.2.8 Qualifying Individuals Group

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

Under the QI Medicaid eligibility group, state Medicaid programs pay the Medicare Part B premiums for individuals who:

- Are entitled to Medicare Part A (including individuals age 65 and over who are only entitled to premium Part A);
- Have income that is at least 120 percent, but less than 135 percent, of the FPL;
- Have resources that do not exceed three times the maximum resource level under the SSI program, adjusted for inflation per section 1905(p)(1) of the Act; and
- Are not otherwise eligible for another Medicaid eligibility group under the state plan.

Starting January 1, 2023, section 402(f) of the CAA, 2021 expanded the QI eligibility group to cover the premiums for Part B-ID immunosuppressive drug coverage (QI Part B-ID) for individuals who:

- Are enrolled in Part B-ID and
- Meet the QI income and resource limits described above.

[37] In 2022, 26 percent of SLMBs qualified for "SLMB-plus", while 74 percent of SLMBs qualified for SLMB-only.

See sections 1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) of the Act; 42 CFR 435.425.

Current federal income and asset limits for QIs are available at https://www.medicaid.gov/medicaid/eligibility/seniors-medicare-and-medicaid-enrollees/index.html. As described in section 1.6.2.1, states can modify their financial eligibility methodologies and requirements above the federal floor.

As with SLMBs, the state is precluded from paying the Medicare Part A premiums for QIs. Similarly, QI determinations may be retroactive for a maximum of three months prior to the month of application, but retroactivity may not extend back to a prior calendar year. Unlike QMB and SLMB, individuals cannot qualify for QI if they are eligible for a separate eligibility group covered under the state plan. Thus, there is no QI-plus category.

State Medicaid programs enroll QIs only to the extent that their state Medicaid program has available funding. The federal government makes annual allotments to states to fund the Part B premiums. See section 1933(g) of the Act.

1.6.3 Buy-in Coverage Group Three: All Medicaid Eligibility Groups

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

In their buy-in agreements, states can elect to pay Medicare Part B premiums for a buy-in coverage group that includes all individuals eligible for Medicaid under the state plan. This "catch-all" group includes the cash assistance groups and three MSP groups above, plus all other individuals who are eligible for Medicaid, including, but not limited to, the poverty-level group for individuals age 65 and older (sections 1902(a)(10)(A)(ii)(X); 1902(m)(1) of the Act); the medically needy (section 1902(a)(10)(C) of the Act; 42 CFR 435.301); and institutionalized individuals eligible under a special income level (section 1902(a)(10)(A)(ii)(V) of the Act; 42 CFR 435.236).

This buy-in coverage group also includes individuals eligible for an optional Medicaid buy-in group for working individuals with disabilities described in sections 1902(a)(10)(A)(ii)(XVIII), (XVI) and (XIII) of the Act provided they remain entitled to premium-free Part A. For individuals under age 65, premium-free Part A continues at least 8 and ½ years following their return to work including a 9-month trial work period. If the individual exhausts their entitlement to premium-free Part A, they no longer qualify for Part B and therefore Part B buy-in coverage (except in the rare case they enroll in premium Part A for working disabled individuals, for which they must pay the Part A premium themselves). See section 1.3.2 for information on Medicare coverage for individuals with disabilities under age 65 who return to work.

This buy-in coverage group does not include individuals who are eligible through section 1115 demonstrations but who do not otherwise qualify for Medicaid benefits included in the state plan.

See section 1843(h)(1)(A) of the Act.[38]

Generally, the effective date of coverage for Medicaid is up to three months before the month of application if all eligibility criteria are met, with exception of the QMB group as described above. See 42 CFR 435.915. The state is precluded from paying the Medicare Part A premiums for SLMBs and QIs.

1.7 State Payment of Part A Premiums for Qualified Medicare Beneficiaries

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

All states must pay the Part A premiums for QMB-eligible individuals who do not have premium-free Part A. However, states can choose one of two methods to pay the Part A premium for QMBs. States can expand their buy-in agreement with CMS under section 1818(g) of the Act to include enrollment and payment of Part A premiums for QMBs who owe a premium for Part A, or they can pay premiums through a group payer arrangement.

States that include payment of Part A premiums for QMBs in their buy-in agreements are called ‘‘Part A buy-in states.’’ As of January 1, 2025, 37 states and the District of Columbia have chosen this option. In Part A buy-in states, individuals determined eligible for the QMB group can enroll in premium Part A at any time of the year and without regard to late enrollment penalties.

States that do not include Part A in their buy-in agreements and instead pay the Part A premiums for QMBs using a group payer arrangement are known as Part A ‘‘group payer states.” As of January 1, 2024, there are fourteen group payer states.[39] The group payer arrangement allows certain parties (for example, states) to pay Part A premiums for a class of beneficiaries. See 42 CFR 406.32(g); SSA POMS HI 01001.230 at https://secure.ssa.gov/poms.nsf/lnx/0601001230.

Group payer states can only enroll individuals in premium Part A during an applicable Medicare enrollment period. Group payer states are also required to pay late enrollment penalties, if applicable, for those individuals who did not enroll in Medicare Part A timely when they first became eligible to do so (i.e., during their Medicare IEP).

See section 1.3.2 for more information about eligibility for premium Part A, section 1.6.2.4 for more information about QMB, and sections 1.10 and 1.11 for information about enrollment in the QMB group for individuals who need to pay a premium to enroll in Part A.

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[38] Section 1843(h)(1)(A) of the Act specifies that buy-in agreements cover “individuals who are eligible to receive medical assistance under the plan of such State approved under title XIX.”

[39] California law requires the state to submit a SPA to become a Part A buy-in state on or after January 1, 2025. See CA S.B. 311, amending CA Welf. & Inst. Code 14005.11 at https://legiscan.com/CA/text/SB311/2023. Upon implementation, the number of group payer states will drop to 13.

See the table in appendix 1.D, which identifies Part A buy-in states and group payer states as of January 1, 2024.

NOTE: While states can choose to pay Part A premiums for individuals in the QMB group through their buy-in agreements or a group payer arrangement, states must pay the Part A premium for individuals in the smaller QDWI group through the group payer arrangement.

1.8 Conversion from Part A Group Payer to Part A Buy-in Status

(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

A group payer state may elect to become a Part A buy-in state at any time. See 42 CFR 406.26(a). To effectuate this change, states must file a SPA to update their state buy-in pages in section 3.2 of the state plan under ‘‘Coordination of Medicaid with Medicare and Other Insurance of their state Medicaid Plan.’’ Interested states should contact the Medicare-Medicaid Coordination Office at ModernizetheMSPs@cms.hhs.gov, which will then coordinate with the state’s Center for Medicare and CHIP Services (CMCS) SPA Coordinator and the Division of Premium Billing and Collections in CMS’ Office of Financial Management (see contact information in chapter 6).

Enrollments under a new buy-in agreement can begin no earlier than the third month after the month in which the agreement is executed (i.e., formal notification is signed by the state and accepted by CMS). See 42 CFR 406.26(b).

1.9 Federal Financial Participation (FFP) for Medicare Costs

(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

States can receive FFP for individuals who are cash assistance recipients and deemed recipients of cash assistance and individuals who eligible for the relevant MSPs. See 42 CFR 431.625. Specifically, states can seek FFP for the state payment of:

- Medicare Part B premiums, deductibles, coinsurance, and copays for cash assistance recipients (SSI/SSPs) and deemed recipients of cash assistance;
- Part A or B premiums, deductibles, coinsurance, and copays for QMBs; and
- Part B premiums for SLMBs and QIs.

The state’s regular FMAP rate applies to these expenditures, except the Part B premiums for QIs, which the federal government fully funds through annual allotments made to states. See section 1933(g) of the Act.

For eligible individuals who are enrolled in any other category of Medicaid, FFP is not available for the state payment of Part B premiums. However, paying the premiums for these individuals under buy-in helps states maximize federal funding for health care services.

First, states cannot obtain FFP for state Medicaid expenditures that could have been paid for under Medicare Part B if the individual had been enrolled in Part B. See 1903(b)(1) of the Act; 42 CFR 431.625(d)(3). In addition, under CMS policy, states cannot require Medicaid applicants and beneficiaries to apply for Medicare as a condition of eligibility unless the state pays any Medicare cost-sharing or premiums the individual incurs.[40] If the state does not pay the Part B premiums for a Medicaid beneficiary and the individual does not enroll in Part B, CMS does not consider Medicare Part B to be a liable third party under 42 CFR part 433, subpart D and, therefore, the state must cover the items and services in accordance with its state Medicaid plan.[41]

State agencies report gross expenditures (total computable) and apply the applicable FMAP on the Quarterly Expenditure Report for Medical Assistance Payments (Form CMS-64).[42]

States should direct any questions about Form CMS-64 to the analyst within the CMCS Financial Management Group (FMG), Division of Financial Operations (DFO) for their state.

1.10 Streamlined Enrollment Under a Buy-in Agreement

(Rev. 6; **Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)**

Buy-in agreements permit states to enroll eligible individuals covered under the agreement in Medicare Part A or B, with the state paying their premiums, **at any time of the year (without regard to enrollment periods).** CMS does not bill states for any applicable late enrollment penalties due to late enrollment. See sections 1843 and 1818(g) of the Act.

States must directly enroll a Medicaid beneficiary included in the state's Part B buy-in coverage group if SSA has determined the individual eligible for Medicare (i.e., the individual is entitled to Part A and/or enrolled in Part B).

For example, if a member of a Part B buy-in coverage group is entitled to premium-free Part A but is not enrolled in Part B, the state should directly enroll the individual in Part B buy-in without referring them to the SSA FO to file for Part B.

Similarly, if a QMB-eligible individual is already enrolled in Part B, a Part A buy-in state should directly enroll that individual in QMB and Part A buy-in (without requiring the individual to first file for Part A at the SSA FO). For additional information about enrolling QMB-eligible

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[40] See final rule titled ''Medicare Program: Implementing Certain Provisions of the Consolidated Appropriations Act, 2021 and Other Revisions to Medicare Enrollment and Eligibility Rules" published in the November 3, 2022 Federal Register (88 FR 66454, 66468) at https://www.govinfo.gov/content/pkg/FR-2022-11-03/pdf/2022-23407.pdf.

[41] See Coordination of Benefits and Third Party Liability (COB/TPL) in Medicaid handbook, chapter 1, section D.1 at https://www.medicaid.gov/sites/default/files/2020-08/COB-TPL-Handbook.pdf.

[42] The expenditures for allowable Medicare Part A premiums are claimed on line 17.A of the Form CMS-64.9 or CMS-64.9P (whichever applies). The expenditures for allowable Medicare Part B premiums are claimed on line 17.B of the Form CMS-64.9 or CMS-64.9P.

individuals without premium-free Part A in the QMB group, see section 1.11.

1.11 Qualified Medicare Beneficiary Enrollment for Individuals Who Need to Pay a Premium to Enroll in Part A

(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

As described in section 1.7, all states must pay the Part A premium for individuals who are enrolled in the QMB eligibility group. Part A buy-in states cover the Part A premiums for QMBs under their buy-in agreements. Group payer states do not include Part A premium payments for QMBs in their buy-in agreement and instead use the group payer arrangement to pay Part A premiums for QMBs.

As described in section 1.6.2.4, to qualify for the QMB group under section 1905(p)(1) of the Act, an individual must be entitled to Part A (see definition of "entitlement to Part A" in section 1.1). Further, section 1905(a) of the Act specifies that payments of Medicare cost-sharing for QMBs (including Part A premiums) are ''medical assistance'' for purposes of FFP, if made in the month following the month in which the individual becomes a QMB.

Because a literal read of the law would produce a result that essentially nullifies the impact of the QMB benefit and buy-in statutory provisions, CMS has a long-standing policy under which states can receive FFP for paying an individual's Part A premium the first month of entitlement, thereby triggering both Part A entitlement and QMB coverage.

For individuals who reside in Part A buy-in states, the process for enrolling in QMB is more streamlined as compared to individuals who reside in group payer states.

Part A buy-in states: Part A buy-in states can determine an individual eligible for the QMB group if they are enrolled in Part B only and not yet entitled to Part A. Enrollment in Part B is sufficient to meet the requirement that the individual be entitled to Part A for the purposes of the state's QMB eligibility determination.

Individuals can enroll in Part A at any time of the year without regard for Medicare enrollment periods or late enrollment penalties if the state pays their Part A premium under its buy-in agreement.[43]

Group payer states: Group payer states can approve eligibility for individuals under the QMB group after SSA has enrolled them in premium Part A or conditional premium Part A (the ''conditional enrollment process"). The conditional enrollment process enables low-income

[43] Note that if a Part A buy-in state resident lacks both Parts A and Part B, the state cannot determine the individual eligible for QMB and enroll them in Part A buy-in until SSA enrolls them in premium Part A or conditional premium Part A. Such individuals can conditionally enroll in premium Part A at any time of the year (without regard for Medicare enrollment periods or late enrollment penalties, if applicable). See SSA POMS HI 00801.140 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801140.

individuals to apply at SSA for premium Part A on the condition that they will only be enrolled in Part A if the state determines they are eligible for the QMB group.

If an individual conditionally files for Part A, then applies for the QMB group with their state Medicaid program, the individual can effectively become simultaneously enrolled in Part A and the QMB group if the individual meets all other QMB eligibility requirements.

The conditional enrollment acts as a placeholder in SSA's system. Premium Part A entitlement is only effective with the individual's enrollment in QMB. The Medicare Part A start date will reflect the QMB start date that the state reports to CMS. If the state does not determine the individual eligible for QMB, SSA will not establish premium Part A entitlement.

When processing the conditional Part A enrollment, SSA will refer the individual to the appropriate state Medicaid office to apply for the QMB group and may give the individual a screen shot of the application to bring to the state as proof of the conditional enrollment. The state can also query SSA's State Verification and Exchange System (SVES) to verify the conditional Part A enrollment. See SSA POMS HI 00801.140 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600801140 for more information about the conditional enrollment process.

Although the conditional enrollment process provides a way for individuals to enroll in the QMB eligibility group without paying their own Part A premiums upfront, it requires individuals to complete a two-step process to enroll in QMB, which can be difficult to complete.

Group payer states can elect to bypass the conditional enrollment process for individuals who have SSI-based Medicaid, are enrolled in Part B only, and are eligible for a Medicare enrollment period, as described in 42 CFR 435.909(b)(2). For more information about this option, see section 1.6.2.6.

Individuals in group payer states who do not enroll in premium Part A or conditional premium Part A during their IEP can only file for premium Part A during the annual GEP (January 1 through March 31) or an applicable SEP.

No later than April 1, 2026, 42 CFR 406.21(c)(5) requires states to start QMB coverage as early as the month Part A entitlement begins (i.e., month after enrollment) for individuals who enroll in premium Part A or conditional premium Part A during a Medicare enrollment period. QMB coverage for such individuals starts the month premium Part A entitlement begins (if the state determines the individual has met the eligibility requirements for the QMB group in the same month that Part A enrollment occurs), or a month later than the month of Part A entitlement (if the individual is determined eligible for the QMB group the month Part A entitlement begins or later).

1.12 Policy Regarding Which Entity Initiates Buy-in

(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

Depending upon the circumstances, CMS or the state will generally initiate buy-in enrollment ("accretion"). This section describes which entity initiates the accretion.

NOTE: In certain circumstances, however, SSA should take steps to initiate Part B buy-in through the Public Welfare Accretion process for Medicaid beneficiaries who file a Medicare application and who are in an eligibility group that is included in the state buy-in agreement. This most commonly occurs when a full-benefit Medicaid beneficiary newly qualifies for Medicare and applies for Medicare Part B before SSA has established Medicare entitlement and before the state or territory has established Part B buy-in. See SSA POMS HI 00815.030 at https://secure.ssa.gov/poms.nsf/lnx/0600815030. The Public Welfare accretion process allows SSA field offices to establish Medicare Part B through state buy-in, making the state responsible for paying the Medicare Part B premiums, instead of the individual.

For more information about PW accretions, see section 2.8; SSA POMS HI 00815.030 at https://secure.ssa.gov/poms.nsf/lnx/0600815030.

1.12.1 Part B Buy-in for Cash-Related Recipients (SSI/SSPs)

(Rev. 6; **Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)**

SSA regularly communicates with states regarding who is entitled to SSI and/or federally administered SSPs through SSA data systems, such as the State Data Exchange (SDX). See section 2.4.2 for a list of SSA systems for states. In addition, SSA sends information to CMS about SSI/SSPs recipients who qualify for Medicare which, in turn, assists states in enrolling cash recipients in Part B buy-in. See section 2.5.1.1 for more information.

The state is responsible for accreting individuals the state has found eligible for Medicaid in the SSI criteria category to the state's buy-in rolls.

In auto-accrete states and states with 1616 agreements, CMS automatically initiates state payment of Part B premiums for individuals ("auto-accretes" them into Part B buy-in) only after SSA notifies CMS that the individual is entitled to SSI and eligible for Medicare. In states with 1616 agreements, CMS will auto-accrete individuals who receive SSI only, or SSI in combination with SSPs, or SSPs-only.

NOTE: Although CMS generally initiates auto-accretions for these individuals, the state is responsible for taking action to ensure all eligible individuals are enrolled in Part B buy-in.

In alert states (SSI criteria and 209(b) states), CMS sends states "SSI alert notification" records for SSI individuals who are also eligible for Medicare. Alert states are responsible for accreting SSI/SSP recipients the state has found eligible for Medicaid to the state's buy-in rolls.

States must always initiate:

- Part A or B buy-in for QMBs;

- Part A buy-in for QDWIs;
- Part B buy-in for deemed recipients of cash assistance;
- Part B buy-in for SLMB and QI; and
- Part B buy-in for other full-benefit Medicaid recipients.

1.13 Definition of Part B Buy-in Coverage Period
(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

1.13.1 Beginning of Part B Buy-in Coverage
(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

For an individual enrolled in the "required eligibility groups" (i.e., cash assistance recipients or deemed recipients of cash assistance) or the three MSPs, Part B buy-in begins the later of:

- The first month in which the individual meets the requirements both for eligibility in the buy-in group (i.e., the effective date of the individual's full-benefit Medicaid or MSP coverage) and eligibility for Medicare Part B; or
- The first month in which the individual meets the requirements both for eligibility in the buy-in group (i.e., the effective date of the individual's full-benefit Medicaid or MSP coverage) and eligibility in the buy-in group (i.e., the effective date of the individual's full-benefit Medicaid or MSP coverage) and eligibility for Medicare Part B; or
- The effective date of the buy-in agreement or modification that includes the buy-in group to which the individual belongs (defined as the third month after the document's execution).

See 42 CFR 407.47(b) and (c).

For an individual enrolled in one of the "other Medicaid eligibility groups" (when the buy-in coverage group includes all Medicaid eligibility groups), Part B buy-in begins the later of:

- The second month after the individual meets the requirements both for eligibility in the buy-in group (i.e., the effective date of the individual's Medicaid coverage) and eligibility for Medicare Part B; or
- The effective date of the buy-in agreement or modification that includes the buy-in group to which the individual belongs (defined as the third month after the document's execution).

See 42 CFR 407.47(d).

As described in sections 1.6.2.4 and 1.6.2.7, many individuals who qualify for the QMB eligibility group and some individuals who qualify for the SLMB eligibility group also separately qualify for a full-benefit Medicaid eligibility group (i.e., QMB-plus, and SLMB-plus). While an individual's separate Medicaid eligibility or SLMB eligibility can be retroactive up to 3 months before the application, QMB eligibility is effective no earlier than the month following the month of the determination of such eligibility. See 42 CFR 435.915 and sections 1902(e)(8) and 1905(a) of the Act. Therefore, if a state determines that an individual is eligible for the QMB eligibility group and a separate Medicaid eligibility group, the Part B buy-in coverage period may start based on the non-QMB Medicaid eligibility group under which the individual is determined eligible before the coverage period corresponding to the QMB eligibility group begins.

To illustrate, for a QMB-plus individual, the start of Part B buy-in coverage is often earlier than the QMB effective date.

For example, if a Medicare-eligible individual—

• Applies for Medicaid on January 1 of a particular calendar year;

• Is determined in January to be eligible under the eligibility group described in section 1902(a)(10)(A)(ii)(X) of the Act (relating to individuals who have incomes up to the FPL and are either 65 years old or older or with disabilities, which is considered an ''other Medicaid eligibility group'') retroactive to October 1 of the previous calendar year;

• Is determined in January to meet all eligibility requirements for the QMB eligibility group; and

• The individual's state has elected to include all Medicaid beneficiaries eligible for Medicare in its Part B buy-in agreement, then, in this example, Part B buy-in starts on November 1 of the previous calendar year (i.e., the buy-in start date for ''other Medicaid eligibility groups,'' which is the second month the individual is eligible for the Medicaid eligibility group and Medicare). Part A buy-in will begin February 1 of the current year.[44]

NOTE: In some instances, SSA determines Medicaid beneficiaries eligible for premium-free Part A for a retroactive period.[45] The individual is also retroactively eligible to enroll in Part B

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[44] While the individual's QMB eligibility under the state plan will not become effective until February of the particular calendar year, Part B buy-in starts on November 1 of the previous calendar year, because the individual was eligible in a Medicaid eligibility group that was included in the state's buy-in coverage group effective in October of the previous calendar year (that is, the buy-in start date for ''other Medicaid eligibility groups,'' which is the second month the individual is eligible for a buy-in coverage group and Medicare).

[45] This generally occurs when an individual under age 65 who files a claim for disability benefits at SSA receives a favorable Social Security Disability Insurance (SSDI) award multiple years after the initial application, and SSA determines the individual eligible for SSDI benefits at or up to 12 months prior to the point of application. Individuals entitled to SSDI become entitled to premium-free Medicare Part A after 24 months of entitlement to SSDI, but in certain cases, an individual's start date for SSDI benefits is retroactive more than 24 months. In that

over this period. If a state learns that SSA established retroactive Medicare Part A entitlement for a member of a buy-in coverage group, the state must review the individual's eligibility for Part B buy-in over the retroactive period.

Beginning January 1, 2024, state liability for retroactive Medicare Part B premiums for full-benefit Medicaid beneficiaries under a buy-in agreement is limited to a period no greater than 36 months prior to the date of the Medicare enrollment determination, as discussed in section 1.4.3. See 42 CFR 407.47(f)(1).

States can request a good cause exception for retroactive periods of less than 36 months if the state could not benefit from Medicare (e.g., based on the state's Medicaid recoupment policy) AND limiting state liability would not result in harm to the beneficiary. The state or beneficiaries can also request a good cause exception for retroactive periods of more than 36 months if a 36-month limit would result in harm to the beneficiary.

In evaluating the good cause exception request, CMS' primary consideration would be whether the beneficiary has unpaid medical bills and needs Medicare coverage during the retroactive period for unpaid medical bills.[46]

States can email DPBCStateBuy-in@cms.hhs.gov to request a good cause exception. Individuals can seek an exception by contacting 1-800-MEDICARE.

1.13.2 End of Part B Buy-in Coverage

(Rev. 6; **Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)**

Part B buy-in coverage ends with the earliest of the events specified below:

- **Loss of membership in the buy-in group –** The last day of the month in which the individual is enrolled in one or more Medicaid categories under the buy-in group.

- **Death –** Coverage ends on the last day of the month in which the individual dies.

- **Loss of enrollment in Medicare Part A –** If an individual is under age 65 and is no longer enrolled in Medicare Part A (i.e., no longer qualifies for SSA disability benefits), Part B buy-in ends on the last day of the last month for which the individual is enrolled in Part A.

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case, the determination of SSDI eligibility for a retroactive period for the individual means that the individual's premium-free Part A entitlement is retroactive as well.

[46] See the Medicare Eligibility and Enrollment final rule (88 FR 66454, 66487) at https://www.govinfo.gov/content/pkg/FR-2022-11-03/pdf/2022-23407.pdf.

- **Termination or modification of the buy-in agreement –** If the state's buy-in agreement is terminated or modified to restrict coverage to a narrower buy-in group, coverage for an individual ends on the last day of the last month for which the agreement is in effect or covers the broader group.

CMS may modify the effective date of the deletion requested by the state based on CMS system processing rules that limit the retroactivity of Part B deletions to two months prior to the "processing month." See 42 CFR 407.48(c)(2). To learn more about CMS processing limits intended to prevent excessive hardship for beneficiaries, see section 2.6.1.3.

If a beneficiary enrolled in a Medicaid eligibility category included in the state's buy-in group experiences a change in circumstance that may impact eligibility, the state must conduct a redetermination based on the change in circumstance. See 42 CFR 435.916(f). See section 1.4.4 for information about state requirements for Medicaid redeterminations and buy-in coverage when an individual enrolled in state buy-in experiences a change in circumstances. For more information about the end of state buy-in, see SSA POMS HI 00815.021 at https://secure.ssa.gov/poms.nsf/lnx/0600815021.

1.14 Definition of Part A Buy-in Coverage Period

(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

1.14.1 Beginning of Part A Buy-in Coverage

(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

Part A buy-in begins the later of:

- The effective date of the buy-in agreement or modification that covers QMBs (defined as the third month after the document's execution); or

- The month the individual is enrolled in premium Part A and QMB.

See 42 CFR 406.26(b).

See sections 1.10 and 1.11 for information about QMB enrollment for individuals who must pay a premium to enroll in Part A.

1.14.2 End of Part A Buy-in Coverage

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

Part A buy-in coverage ends with the earliest of the events specified below:

- **Loss of QMB status** – The last day of the month in which the individual is enrolled in the QMB group.

- **Death** – Coverage ends on the last day of the month in which the individual dies.

- **Enrollment in premium-free Part A** – If an individual enrolls in premium-free Part A, Part A buy-in coverage ends on the last day of the last month the individual is enrolled in premium Part A, at which point the beneficiary will be entitled to premium-free Part A.

- **Termination of the Part A buy-in agreement** – If the state terminates its Part A buy-in agreement (i.e., removes the payment of Part A premiums for QMB from the buy-in agreement), coverage through the buy-in agreement will end. However, payment of the Part A premiums for QMB individuals must continue under the group payer arrangement.

CMS may modify the effective date of the deletion requested by the state based on the CMS regulation limits the Part A deletion date to the month CMS receives the deletion. See 42 CFR 406.26(c). CMS terminates (deletes) Part A buy-in coverage effective at the end of the month in which the state's deletion request is received (up until the last business day of the month), even if the individual lost eligibility in an earlier month. To learn more about CMS processing of Part A deletion requests for individuals who lose QMB status, see section 2.6.1.4.

1.15 Implications for Beneficiaries When State Buy-in Coverage Ends
(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

When a state stops paying the Part A or Part B premium for an individual, Medicare enrollment continues without interruption, with the beneficiary assuming responsibility for paying the premiums. See 42 CFR 406.26(d) and 407.50(a).

- Premiums paid under a state buy-in agreement: The beneficiary is deemed to have enrolled during the IEP and is liable for the standard base premium amount even if they had been paying a late enrollment penalty prior to enrollment in buy-in.

- Premiums paid under state group payer arrangement: The beneficiary becomes liable for the premium amount the state paid (i.e., the Medicare Part A premium may be subject to a late enrollment penalty if the state had been paying one).

If the beneficiary receives Social Security (OASDI), RRB or OPM benefits, the respective issuing entity deducts the Part B premium amount from their monthly benefit payment. If the beneficiary does not receive Social Security, RRB or OPM benefits, CMS will directly bill them for Medicare Part A and/or B premiums.[47]

For more information about the implications when buy-in ends, see SSA POMS HI 00815.021 at https://secure.ssa.gov/poms.nsf/lnx/0600815021.

For information about beneficiary options for financial relief from retroactive Part B premium when buy-in ends, see section 1.15.2.

1.15.1 Voluntary Withdrawal (Termination) From Medicare
(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

Once the state ends buy-in coverage (or state payment of Part A premiums for QMBs in group payer states), SSA will mail the beneficiary a notice of state buy-in termination ("buy-out notice").

The buy-out notice describes the option to withdraw from Medicare Part A and/or Part B. If the beneficiary files Form CMS-1763 (Request For Termination of Premium Part A, Part B or Part B Immunosuppressive Drug Coverage)[48] within 30 days of the buy-out notice date, Part A and/or

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[47] Part B premiums are billed quarterly, whereas Part A alone and Part A and Part B combined are billed monthly. A grace period for premium payment extends until the end of the third month of unpaid premiums; after 90 days the direct billing notice will include a termination date of coverage. See SSA POMS HI 01001.030 at https://secure.ssa.gov/poms.nsf/lnx/0601001030.

[48] Form CMS-1763 is available at https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms1763.pdf.

Part B will generally terminate the month buy-in has ended.

NOTE: The notice may be dated after buy-in has already terminated.

- If the beneficiary files Form CMS-1763 during the six months following the loss of buy-in, Medicare coverage ends at the end of the month in which the beneficiary filed the notice.

- If a beneficiary waits more than six months after buy-in coverage ends to file Form CMS-1763, Medicare coverage ends at the end of the month after the month in which the beneficiary notifies SSA or CMS that they wish to withdraw.

1.15.2 SSA Options for Financial Relief from Retroactive Premium Billing

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

SSA may initially deduct from OASDI benefit payments premium amounts of up to three months (current month plus two retroactive months) when Part B buy-in coverage ends.[49]

Beneficiaries can pursue either or both of the options below to obtain financial relief from retroactive Part B (or Part A) premium billing.

- Premium Waiver - Beneficiaries who believe they cannot afford to pay the retroactive premiums can request a premium waiver by submitting a Request for Waiver of Overpayment Recovery, available at https://www.ssa.gov/forms/ssa-632-bk.pdf to their local SSA office. If SSA grants the waiver request and has already deducted retroactive Medicare premiums from the beneficiary's benefit payment or the individual has made the direct premium payment to CMS, SSA will refund the waived amount to the beneficiary. See SSA POMS HI 00830.015 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600830015 for more information about retroactive premium waivers.

- Installment Payments for Retroactive Premiums - Beneficiaries may request an installment plan for retroactive premiums from their local SSA office or by contacting SSA's national 800 number (1-800-772-1213 or TTY 1-800-325-0778). To qualify, individuals must attest they cannot afford to pay the retroactive premiums in one lump sum. Installment payments must be at least $15 per month. If SSA approves an installment plan and has already deducted retroactive Medicare premiums from the beneficiary's benefit payment or the individual has made the direct premium payment to CMS, SSA will refund to the beneficiary the retroactive premiums less the installment payments owed. For more information about installment payments, see SSA POMS HI

[49] See section 2.6.1.3, SSA POMS HI 00815.042 at http://policynet.ba.ssa.gov/poms.nsf/lnx/0600815042, SSA POMS HI 01005.001 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0601005001, and SSA POMS HI 01005.015 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0601005015.

00805.180 at https://secure.ssa.gov/poms.nsf/lnx/0600805180 and SSA POMS HI 00830.060 at https://secure.ssa.gov/apps10/poms.nsf/lnx/0600830060.

Appendix 1.A Dual Eligibility Categories and Assistance with Medicare Part A and Part B Costs

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

Category	Monthly Income*	Resources*	Covers Part A premium (when applicable)	Covers Part B premium	Covers Part B-ID premium	Covers Parts A and B cost-sharing	Covers Part B-ID cost sharing	Full-benefit Medicaid coverage**
QMB-only	FPL ≤ 100%	<3 times the SSI resource limit, adjusted for inflation*	X	X		X***		
QMB-plus**	FPL ≤ 100%	<3 times the SSI resource limit, adjusted for inflation*	X	X		X***		X
QMB-Part B-ID	FPL ≤ 100%	<3 times the SSI resource limit, adjusted for inflation*			X		X	
SLMB-only	> 100% FPL < 120%	<3 times the SSI resource limit, adjusted for inflation*		X				
SLMB-plus**	> 100% FPL < 120%	<3 times the SSI resource limit, adjusted for inflation*		X		Depends on state plan*****		X
SLMB-Part B-ID	> 100% FPL < 120%	<3 times the SSI resource limit, adjusted for inflation*			X			

Category	Monthly Income*	Resources*	Covers Part A premium (when applicable)	Covers Part B premium	Covers Part B-ID premium	Covers Parts A and B cost-sharing	Covers Part B-ID cost sharing	Full-benefit Medicaid coverage**
QI	≥ 120% FPL < 135%	<3 times the SSI resource limit, adjusted for inflation*		X				
QI-Part B-ID	≥ 120% FPL < 135%	<3 times the SSI resource limit, adjusted for inflation*			X			
QDWI	≤200% FPL	<2 times the SSI resource limit	X					
Full-benefit Medicaid **	Determined by state	Determined by state		Depends on state Buy-in Agreement****		Depends on state plan*****		X

* CMS releases the income and resource limits for all states and the District of Columbia annually. Higher income limits apply for Alaska and Hawaii. The resource limit calculation for QMBs, SLMBs, and QIs is three times the SSI resource limit, adjusted for inflation per section 1905(p)(1) of the Act. In determining countable income and resources for MSP eligibility, states must use income and resource methodologies no more restrictive than SSI's. However, under the authority of section 1902(r)(2) of the Act, states have the flexibility to adopt more liberal income and resource methodologies than used by SSI to effectively increase the QMB, SLMB and QI income and/or resource limits above the federal limits. Some states have used section 1902(r)(2) authority to effectively eliminate any resource criteria for the MSP groups.

** "Full-benefit" Medicaid coverage, in the context of individuals who are considered dually eligible, generally refers to coverage for a range of items and services, beyond coverage for Medicare premiums and cost-sharing, that certain individuals are entitled to under 42 CFR 440.210 and 440.330. Individuals who are QMB-plus/SLMB-plus receive full-benefit Medicaid in addition to Medicare cost-sharing and premiums coverage. Individuals who receive full-benefit Medicaid only are entitled to Medicare Part A and/or enrolled in Part B, and qualify for full-benefit Medicaid benefits, but not the QMB or SLMB eligibility groups.S

*** While individuals enrolled in QMB-only and QMB-plus do not pay Medicare deductibles, coinsurance, or copays, they may have a small Medicaid copay for services that Medicare and Medicaid cover.

**** States pay the Part B premiums if they include all Medicaid categories in their Part B buy-in coverage group.

***** Beneficiary pays no more than the Medicaid copay amount (if applicable) for state plan services covered by both Medicare and Medicaid if the provider participates in Medicaid. Also, all Medicare providers (regardless of Medicaid participation) must accept the Medicare-allowed amount ("Medicare assignment") as payment in full for Part B services furnished to dual eligible beneficiaries.

Appendix 1.B Dual Eligibility Category Descriptions

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

Qualified Medicare Beneficiaries (QMBs) without other Medicaid (QMB-Only – also known as QMB "partial-benefit") are enrolled in Medicare Part A (or if uninsured for Part A, have filed for premium Part A on a conditional basis), have income up to 100 percent of the federal poverty level (FPL) and resources that do not exceed three times the limit for supplementary security income (SSI) eligibility with adjustments for inflation, and are not otherwise eligible for full-benefit Medicaid coverage. Medicaid pays their Medicare Part A premiums, if any, and Medicare Part B premiums. Medicare providers may not bill QMBs for Medicare Parts A and B cost-sharing amounts, including deductibles, coinsurance, and copays.[50] Providers can bill Medicaid programs for these amounts, but states have the option to reduce or eliminate the state's Medicare cost-sharing payments by adopting policies that limit payment to the lesser of (a) the Medicare cost-sharing amount, or (b) the difference between the Medicare payment and the Medicaid rate for the service.

Individuals in the limited Part B-ID benefit may also qualify for the QMB eligibility group with coverage limited to the Part B-ID premium and/or cost-sharing, a status known as QMB-Part B-ID.

QMBs with full-benefit Medicaid (QMB-Plus – also known as QMB "full-benefit") meet the QMB-related eligibility requirements described above and the eligibility requirements for a separate categorical Medicaid eligibility group covered under the state plan. In addition to the coverage for Medicare premiums and cost-sharing described above, QMB-plus individuals receive the full range of Medicaid benefits applicable to the separate eligibility group for which they qualify. Medicaid pays their Medicare Part A premiums, if any, and Medicare Part B premiums. Medicare providers may not bill QMBs for Medicare Parts A and B cost-sharing amounts, including deductibles, coinsurance, and copays.[51] Providers can bill Medicaid programs for these amounts, but states have the option to reduce or eliminate the state's Medicare cost-sharing payments by adopting policies that limit payment to the lesser of (a) the Medicare cost- sharing amount, or (b) the difference between the Medicare payment and the Medicaid rate for the service. QMBs with full-benefit Medicaid pay no more than the Medicaid copay (if applicable) for services covered in the state plan (i.e., services furnished by a Medicaid provider and that Medicaid covers, but Medicare does not). These individuals pay Medicare cost-sharing for Medicare-covered care not included in the state plan unless the state chooses to pay these costs.

Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB-

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[50] However, states may charge QMBs a nominal Medicaid copay for services that Medicare and Medicaid cover in accordance with section 1916(a) of the Act.

[51] However, states may charge QMBs a nominal Medicaid copay for services that Medicare and Medicaid cover in accordance with section 1916(a) of the Act.

Only – also known as SLMB "partial-benefit") are enrolled in Part A and have income between 100 and 120 percent of the FPL, and resources that do not exceed three times the limit for supplementary security income (SSI) eligibility with adjustments for inflation. Medicaid pays only the Medicare Part B premiums for this group.

Individuals enrolled in the limited Part B-ID benefit are also eligible for the SLMB-Only group, if they meet the SLMB income and resource requirements described in the preceding paragraph. For these individuals, Medicaid pays the Part B-ID premium.

SLMBs with full-benefit Medicaid (SLMB-Plus – also known as SLMB "full-benefit") meet the SLMB-related eligibility requirements described above, and the eligibility requirements for a separate categorical Medicaid eligibility group covered under the state plan. In addition to coverage for Medicare Part B premiums, these individuals receive full-benefit Medicaid coverage (i.e., the package of benefits provided to the separate Medicaid eligibility group for which they qualify). For Medicaid-covered services (i.e., services furnished by a Medicaid provider and that either: (1) Medicare and Medicaid, or (2) Medicaid, but not Medicare, cover), a SLMB-Plus beneficiary pays no more than a nominal Medicaid copay (if applicable).[52]

Qualifying Individuals (QIs) are enrolled in Part A and have income of at least 120 but less than 135 percent of the FPL, resources that do not exceed three times the limit for SSI eligibility with adjustments for inflation and are not eligible for **any other** eligibility group under the state plan. QIs receive coverage for their Medicare Part B premiums, to the extent their state Medicaid programs have available slots. The federal government makes annual allotments to states to fund the Part B premiums.

Individuals enrolled in the limited Part B-ID benefit are also eligible for the QI group, if they meet the QI requirements described in the preceding paragraph. For these individuals, Medicaid pays the Part B-ID premium.

Qualified Disabled and Working Individuals (QDWIs – also known as QDWI "partial-benefit") became eligible for premium-free Part A by virtue of qualifying for Social Security Disability Insurance (SSDI) benefits, but lost those benefits, and subsequently premium-free Medicare Part A, after returning to work. QDWIs have income that does not exceed 200 percent of the FPL, resources that do not exceed two times the SSI resource standard and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.

Full-benefit Medicaid: These individuals are entitled to Medicare Part A and/or enrolled in Part B, and qualify for full Medicaid benefits, but not the QMB or SLMB groups. Individuals in this category are sometimes referred to as "other full duals." Full-benefit Medicaid coverage refers to the package of services, beyond coverage for Medicare premiums and cost-sharing, that certain individuals are entitled to under 42 CFR 440.210 and 440.330. For Medicaid-covered services (i.e., services furnished by a Medicaid provider and that either: (1) Medicare and Medicaid, or

[52] States may apply cost-sharing, such as copayments, deductibles, and/or premiums, to certain Medicaid beneficiaries in accordance with 42 CFR 447.52 to 447.56.

(2) Medicaid, but not Medicare, cover), a full-benefit Medicaid beneficiary pays no more than the Medicaid coinsurance[53] (if applicable). For Medicare-only covered services (i.e., services covered by Medicare, but not Medicaid), these individuals pay the Medicare cost-sharing unless the state chooses to cover Medicare cost-sharing for all Medicare- covered services for this eligibility group.

[53] States may apply Medicaid cost-sharing, such as copayments, deductibles, and/or premiums, to certain Medicaid beneficiaries in accordance with 42 CFR 447.52 through 447.56.

Appendix 1.C Medicaid Effective Dates and Buy-in Start and Stop Dates

(Rev. 6; Issued:04-26-24; Effective:04-26-24; Implementation:04-26-24)

	Cash assistance (SSI/SSPs) and Deemed Recipients of Cash Assistance Eligibility Groups	**QMB Eligibility Group**	**SLMB Eligibility Group**	**QI Eligibility Group**	**Other Full-Benefit Medicaid Eligibility Groups**
Medicaid eligibility effective up to 3 months before the month of application. 42 CFR 435.915(a)	✓		✓	✓	✓
Medicaid eligibility effective the month after the month of the QMB eligibility determination. Section 1902(e)(8) of the Act		✓			
Part B Buy-in coverage starts the month an individual qualifies for Medicare and is eligible for a Medicaid group in the buy-in agreement.*, ** 42 CFR 407.47(a)-(c)	✓	✓	✓	✓	
Part B Buy-in coverage starts the second month after an individual qualifies for Medicare and is eligible for a Medicaid group in the buy-in agreement.*, ** 42 CFR 407.47(d)					✓
Part A buy-in coverage starts the month QMB coverage starts.* 42 CFR 406.26(b)		✓ In group payer states only:			

		As early as the month after actual/ conditional Part A application occurred during the GEP or an applicable SEP.			
Part B buy-in disenrollment due to loss of eligibility for any Medicaid group in buy-in agreement effective the month after Medicaid coverage ends. *** 42 CFR 407.48(c)	✓	✓	✓	✓	✓
Part A buy-in disenrollment based on loss of QMB eligibility is effective the month after QMB ends.**** 42 CFR 406.26 (c)(2)		✓			

*This date applies if a buy-in agreement is already in effect; currently, all states include MSPs in their Part B buy-in agreements. Thirty-six states and the District of Columbia have Part A buy-in agreements.

** Note: Starting January 1, 2024, if a full-benefit Medicaid beneficiary is retroactively enrolled in Medicare, state liability for retroactive Part B premiums for such individuals is limited to a period no greater than 36 months prior to the date of the Medicare enrollment determination. See 42 CFR 407.47(f); section 1.4.3.

*** CMS may modify the effective date of the Part B deletion requested by the state. CMS limits the retroactivity of Part B deletions to two months prior to the "processing month." See section 2.6.1.3.

**** CMS may modify the effective date of the Part A deletion requested by the state. CMS limits the Part A deletion date to the month CMS processes the deletion. See section 2.6.1.4.

Appendix 1.D Policies Related to Buy-in in the 50 States, the District of Columbia, and Specified U.S. Territories

(Rev. 7; Issued:01-16-2025; Effective01-16-2025; Implementation: 01-16-2025)

State/Territory[54]	SSI Status Accrete or Alert	Part A Buy-in	Part A Group Payer [55]	Part B Buy-in coverage group[56]
Alabama	Accrete		X	All Medicaid groups
Alaska	Alert (SSI-criteria)	X		All Medicaid groups
Arizona	Accrete		X	All Medicaid groups
Arkansas	Accrete	X		All Medicaid groups
California	Accrete	X		All Medicaid groups
Colorado	Accrete		X	All Medicaid groups
Commonwealth of Northern Mariana Islands	N/A	N/A	N/A	All Medicaid groups
Connecticut	Alert (209b)	X		Cash assistance/MSPs
Delaware	Accrete	X		All Medicaid groups
District of Columbia	Accrete	X		All Medicaid groups
Florida	Accrete	X		All Medicaid groups
Georgia	Accrete	X		All Medicaid groups
Guam	Alert	N/A	N/A	All Medicaid groups
Hawaii	Alert (209b)	X		All Medicaid groups
Idaho	Alert (SSI-criteria)	X		Cash assistance/MSPs

[54] Policies in this table are current as of January 1, 2024. As of this date, the 50 states, the District of Columbia, and specified U.S. territories (the Commonwealth of Northern Mariana Islands, Guam, the U.S. Virgin Islands) have entered into buy-in agreements with CMS.

[55] States can choose to pay Part A premiums for QMBs through their buy-in agreements or a group payer arrangement. Federal law requires states to pay the Part A premiums for QDWIs through the group payer arrangement.

[56] As of January 1, 2024, the 50 states and the District of Columbia have chosen 1 of 2 Part B buy-in coverage groups: (1) Cash Assistance Recipients and Deemed Cash Assistance Recipients Plus Three MSPs (“Cash Assistance/MSPs”) or (2) All Medicaid eligibility groups ("All Medicaid Groups”). The Commonwealth of Northern Mariana Islands, Guam, the U.S. Virgin Islands do not cover the MSPs but cover all Medicaid groups.

State/Territory[54]	SSI Status Accrete or Alert	Part A Buy-in	Part A Group Payer [55]	Part B Buy-in coverage group[56]
Illinois	Alert (209b)		X	Cash assistance/MSPs
Indiana	Accrete	X		All Medicaid groups
Iowa	Accrete	X		All Medicaid groups
Kansas	Alert (SSI-criteria)		X	All Medicaid groups
Kentucky	Accrete		X	Cash assistance/MSPs
Louisiana	Accrete	X		Cash assistance/MSPs
Maine	Accrete	X		Cash assistance/MSPs
Maryland	Accrete[57]	X		All Medicaid groups
Massachusetts	Accrete	X		Cash assistance/MSPs
Michigan	Accrete	X		All Medicaid groups
Minnesota	Alert (209b)	X		Cash assistance/MSPs
Mississippi	Accrete	X		All Medicaid groups
Missouri	Alert (209b)		X	Cash assistance/MSPs
Montana	Accrete	X		Cash assistance/MSPs
Nebraska	Alert (SSI-criteria)		X	Cash assistance/MSPs
Nevada	Alert (SSI-criteria)	X		All Medicaid groups
New Hampshire	Alert (209b)	X		Cash assistance/MSPs
New Jersey	Accrete		X	All Medicaid groups
New Mexico	Accrete		X	All Medicaid groups
New York	Accrete	X		Cash assistance/MSPs
North Carolina	Accrete	X		All Medicaid groups
North Dakota	Alert (209b)	X		Cash assistance/MSPs

[57] Although Maryland has a 1634 agreement, CMS does not auto-accrete SSI recipients who are Medicare-eligible in Part B buy-in. Instead, Maryland initiates Part B buy-in enrollment for Medicare-eligible SSI recipients.

State/Territory[54]	SSI Status Accrete or Alert	Part A Buy-in	Part A Group Payer [55]	Part B Buy-in coverage group[56]
Ohio	Accrete	X		All Medicaid groups
Oklahoma	Alert (SSI-criteria)	X		Cash assistance/MSPs
Oregon	Alert (SSI-criteria)	X		All Medicaid groups
Pennsylvania	Accrete	X		Cash assistance/MSPs
Rhode Island	Accrete	X		Cash assistance/MSPs
South Carolina	Accrete		X	All Medicaid groups
South Dakota	Accrete	X		Cash assistance/MSPs
Tennessee	Accrete	X		Cash assistance/MSPs
Texas	Accrete	X		Cash assistance/MSPs
Utah	Alert (SSI-criteria)		X	All Medicaid groups
Vermont	Accrete	X		Cash assistance/MSPs
Virginia	Alert (209b)		X	All Medicaid groups
U.S. Virgin Islands	N/A	N/A	N/A	All Medicaid groups
Washington	Accrete	X		All Medicaid groups
West Virginia	Accrete	X		Cash assistance/MSPs
Wisconsin	Accrete	X		Cash assistance/MSPs
Wyoming	Accrete	X		All Medicaid groups